



Online Application Patient Guide

This guide details the use of the Delaware patient portal to register for the system and submit an application. **Prior to registering and completing your medical marijuana application online, please contact your physician and ask them if they have signed up to participate in the online application certifications. If your physician has not signed up to participate you will be unable to complete your application online.** You can still have your physician complete the paper medical marijuana application and submit via US mail. Please if you have any questions contact the Medical Marijuana Program at 302-744-4749.

Medical Marijuana Web Page:

<http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html>

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

Welcome to the State of Delaware Medical Marijuana Program. The Division of Public Health (DPH) implemented Title 16, Ch 49A of the Delaware Code after Governor Jack Markell signed Senate Bill 17 in May of 2011; the Delaware Medical Marijuana Act regulates the medical use of marijuana in Delaware.

The purpose of the Medical Marijuana Program is to allow the beneficial use of medical marijuana in a regulated system for alleviating symptoms caused by debilitating medical conditions and their medical treatments.

The mission of the Office of Medical Marijuana (OMM) is protection of Delaware citizens through proactive monitoring and enforcement of the Delaware Medical Marijuana Act and accompanying regulations. Rigorous inspection of the regulated vendors minimizes the risk to human health and environmental impact.

To begin, click on the New Program Participants button if you would like to begin an application or click on the Existing Program Participants button if you have previously registered.

If you have any questions throughout the application process, please contact the Medical Marijuana Program at 302-744-4749.

If you are new or an existing Program participant in the Delaware Medical Marijuana Program you must register as a new program participant in order to complete your application online.

[New Program Participants](#)



[Existing Program Participants](#)

System Registration

Before system use, each user must register using the provided registration form. To register a new user, navigate to 'Registration'



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Medical Marijuana

For the most current information regarding this application, medical marijuana laws in the State of Delaware, and more see the official website: <http://dhss.delaware.gov/dhss/dph/hsp/medmarhome.html>

Login

* Email

* Password

[Registration](#)

[Forgot password](#)

[Login](#)

On the registration screen (shown below) input the patient's information into the provided fields.



Registration

* First Name

* Last Name

* Email

* Password

[Generate](#)

* Password confirmation

[Submit](#)

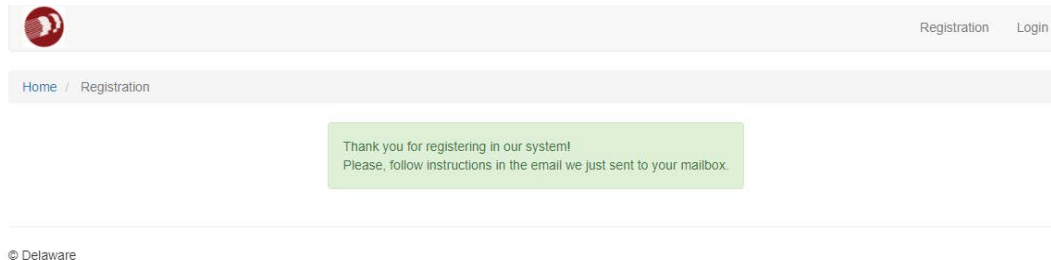
- First Name – First name of the patient.
- Last Name – Last name of the patient.





- Email – Email address of the patient.
- Password – Must follow the rules shown below, input the same password into the Password confirmation field.

After filling in all provided fields, click the Submit button to process the registration. If all information has been entered correctly the following screen will appear:



Next, navigate to your email and click on the registration link in the confirmation email. That confirms the registration and the account is now ready for use. Note: If the email does not appear in your inbox, check the spam folder.

Login to the System

To login to the portal navigate to ** and input the user name and password created during registration and click 'Login' to log into the system.



Login

* Email

* Password

[Registration](#) [Forgot password](#) [Login](#)

© Delaware

Forgot Password

In the event of a forgotten password, navigate to the login screen and click on 'Forgot password' (as shown below).

Login

* Email

* Password

[Registration](#) [Forgot password](#) [Login](#)

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On this screen, enter the user's email address and click the submit button.



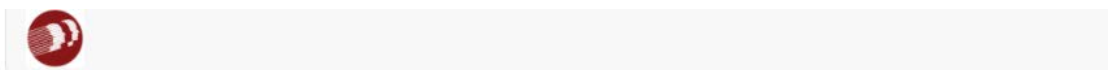
Forgot password

* Email

Submit

© Delaware

If the following screen appears navigate to your email and follow the instructions given in the password reset message. If an error message appears you may need to register for an account.



Success!

Please, follow instructions in the email we just sent to your mailbox.

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Navigate to your email and click on the registration link in the confirmation email. On the screen that appears input a new password and confirm the new password. Note: If the email does not appear in your inbox, check the spam folder.



Patient Account Information Screen

This section details the various icons and information displayed on the patient information screen.

Prior to registering and completing your medical marijuana application online, please contact your physician and ask them if they have signed up to participate in the online application certifications. If your physician has not signed up to participate you will not be able to complete your application online. Your physician can complete the paper medical marijuana application and submit via US mail. Please if you have any questions contact the Medical Marijuana Program at 302-744-4749

[Home](#) / [Account](#) / [Own Applications](#)

Own Applications

Action	Barcode	Application	Percentage	Expiration Date
Preview Renewal Replace	UE146291PK	Issued Patient Application	100%	05-22-2019
7M49PB1GR3	Submitted/Ready for Review Patient Application Renewal: 04-24-2018			

Adverse Event Report

An adverse event is a health-related event associated with the use of a product that is undesirable, and that is unexpected or unusual.

Remit payment to:

Delaware Division of Public Health
ATTN: MMP, Suite 130
417 Federal Street
Dover, De. 19901

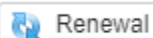
Please include Application Barcode into payment description or Pay Online.

[MAKE PAYMENT](#)

© Delaware



Preview - This button is used to preview the patient application.



Renewal – This button is used to renew the patient application.



Replace – Used to request a replacement card because it's been lost/stolen, the patient's name or address has changed. Select a replacement reason to begin the card replacement.



Card Replacement Reason

Lost or Stolen Card

Change of Address

Change of Name, i.e. recent marriage

Cancel



Fuel Gauge – Icon used to display the patient’s remaining limit meter. When the fuel gauge is clicked, the limit meter screen displays:

0

Limit Meter



UE14629IPK John McGaddy 85.05 Grams / 85.05 Grams

100% Left

Ok

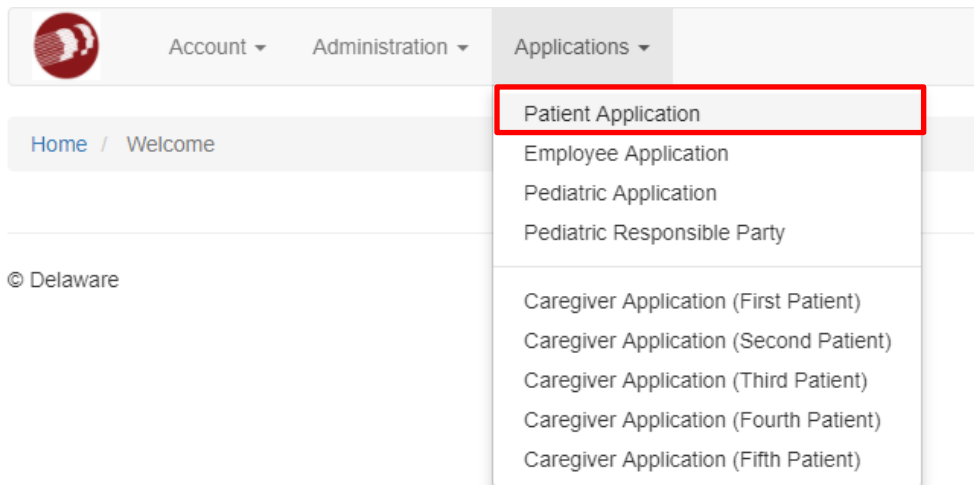
The Application(s) ID and patient name displays along with the remaining limit/full limit available for purchase to the right

. The remaining patient limit is also displayed as a percentage bar that indicates the percentage of the patient limit the remains available for purchase.



Patient Application

Use the patient application section of the portal to submit and review patient application(s). To access the patient application, navigate to Applications> Patient Application:



This brings up the patient application:



Medical Marijuana Patient Application

Applicant Photo

New Patient Renewing Patient

Yes No

100%
75%

Patient Contact Information

Last Name Suffix

First Name Middle Name

Please, pay attention while filling address fields.
They should be filled as example: Address Number: 123 Street Name: Main Street Type: Drive
Please, split address to needed fields carefully.

Address Number Street Prefix

Street Name Street Type

Address (Apt #, P.O. Box, Suit #)

County State

City ZIP Code

Complete the following fields on the application:

- Click +Upload to select and upload a picture of the patient
- Select either New or Returning patient
- Last Name – Input the patient’s last name
- First Name – Input the patient’s first name
- Suffix – Enter the name Suffix, if any (optional)
- Middle Name – Input the patient’s middle name (if any)
- Enter the patient’s full address including county into the provided fields
- Enter the patient’s full mailing address into the provided fields



Mailing Address

Address (Street) Address (Apt #, P.O. Box, Suit #)

County State

City ZIP Code

Primary Phone Secondary Phone

Email Address

At least one option should be filled

Male Female

Date of Birth (Must be 18 or Older)

Weight (lbs)

Height feet inches

ID type Driver's License/State ID Number Driver's License/State ID Exp. date

- Enter the primary phone number for the patient and secondary number if applicable
- Enter the patient's email address
- Select the patient's gender
- Input the patient's date of birth in MM-DD-YYYY format
- Enter the weight in pounds of the patient into the weight field
- Enter the height of the patient into the feet and inches fields
- Select the identification type for the patient and input the ID number and the expiration date into the provided fields.

The next section to complete is voluntary demographic information. Optionally input your demographic information by answering the questions using the radio buttons and/or typing the answers in as needed.



Voluntary Demographic Information

Your voluntary answers are requested - check the items that apply. It is the policy of the State of Delaware to assure equal and fair treatment in all aspects of healthcare for all Delaware residents. The information on this page will only be used to document and assess the effectiveness of our outreach and will not be used for eligibility determination. Under the Health Insurance Portability and Accountability Act (HIPAA), personally identifiable information is protected. De-identified patient information is used for research purposes. Aggregate, de-identified patient information can be published and shared with third parties.

Single Married Divorced Separated Widowed Unmarried Partnership

Hispanic or Latino Caucasian / White Asian Native Hawaiian or Pacific Islander

African American / Black American Indian or Alaskan Native Other

How well do you speak English?

Very Well Well Not Well Not at All

Do you speak another language other than English at home?

No Yes, Spanish Yes, not Spanish, specify

Are you a United States veteran?

No Yes

Are you a citizen or lawful resident of the United States of America?

No Yes

What is your highest level of education completed?

Some High School Completed High School Diploma / GED Technical School

Community College / 2-Yr Degree University / 4-Yr College Master Program or Above

Are you currently enrolled in school?

No Yes, please specify

Are you currently employed?

No Yes, part-time Yes, full-time

On the Patient release of medical information, read the statement input the patient's name, qualifying condition, the certifying position and I and the patient's signature.



Patient Release of Medical Information

PATIENT'S INSTRUCTIONS: Complete and sign the following release statement. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician(s) relating to your qualified medical condition. This form must be submitted with your patient enrollment application. If this form is omitted, your application will be considered incomplete and will be denied.

Patient Release Request

I , (patient),

hereby authorize the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Medical Marijuana Program (MMP) to discuss my medical condition, including treatment records, test results, and evaluations specific to

, (patient's qualifying condition), with my certifying medical provider:

, (physician's full name),

I understand that I may revoke this release at any time. I also understand that if I wish to revoke this authorization, I must do so in writing to the Delaware Medical Marijuana Program, and that revocation may result in the inability of the program to certify me as a Medical Marijuana Program participant. Additionally, I understand that the revocation will not apply to the information that has already been released in response to this authorization.

This information disclosed pursuant to the authorization is subject to potential re-disclosure by the recipient, and will not be protected by the HIPAA privacy rule. I understand that this disclosure is voluntary and that signing this form is not necessary in order to receive treatment from the Delaware Department of Health and Social Services. This release is required; however, to verify my eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my enrollment status with law enforcement; but only for the purpose of verifying that a person is lawfully enrolled in the Medical Marijuana Program, or in the event that the Medical Marijuana Program administrator or designee has reason to believe that a qualified patient-applicant may have violated an applicable law.

This authorization will expire one (1) year from the date signed below unless a different expiration date, less than one (1) year, is specified here:

I understand that completing the signature block electronically constitutes a legal signature confirming that I acknowledge and agree to the above statement

Patient's Signature

Caregiver Authorization Form

Complete this section if you need a Caregiver. The Caregiver must complete a separate application.

The next section is the caregiver authorization form. If applicable enter the caregiver information and have the patient sign in the patient signature field and input the date.



Caregiver Authorization Form

Complete this section if you need a Caregiver. The Caregiver must complete a separate application.

I , (patient),

hereby authorize the following person to be my designated caregiver for the Delaware Medical Marijuana Program. I authorize this caregiver to assist me in the transportation and storage of my medical marijuana. This person will be responsible for managing my well-being with respect to the use of medical marijuana.

Caregiver's First Name Caregiver's Last Name

Caregiver's Date of Birth

This authorization will expire with the expiration of the patient's registry card and will need to be reauthorized with each caregiver renewal.

I understand that completing the signature block electronically constitutes a legal signature confirming that I acknowledge and agree to the above statement

Patient's Signature

FINES ESTABLISHED FOR NON-COMPLIANCE

The following fines have been established in the Medical Marijuana Act:

Failure to notify program staff of patient / caregiver changes in information	\$150.00
Dispersing marijuana to a non-card holder	\$2,000.00
Fraudulent card creation or use	\$1,150.00
Unethical professional conduct	\$3,000.00

FEE SCHEDULE

The following fee schedule has been established in the Medical Marijuana Act. Applicants must include payment with the completed application payable to the State of Delaware, Medical Marijuana Program. Applicants can apply for an application fee waiver by completing a Low Income Charge Request form. Contact the Office of Medical Marijuana to obtain this form and submit with the application. Failure to submit payment or Low Income Charge Request with the application may result in denial of application or delay in processing.



In the next sections, review the established fines and fee schedule before selecting the type of payment used to pay the application fee. If 'Online Payment' is selected click on 'Make Payment' to submit payment. If 'Fee Waiver' is selected click '+Upload' to upload the fee waiver.



Application Fee (registration effective for one year from issue date)	\$125.00
Renewal Fee	\$125.00
Return Check Fee	\$35.00
Card Re-Issue Fee	\$20.00

The Office of Medical Marijuana will not proceed with the processing of your application until the application fee is received.

Application Fees are non-refundable.

Remit Payment to:
Delaware Division of Public Health
ATTN: MMP, Suite 130 417 Federal Street
Dover, DE 19901

At least one option should be filled

Check/Money Order Online Payment Fee Waiver

If requesting Fee Waiver, please upload Fee Waiver Request Form here

[Fee Waiver Request](#)

To be completed by Department of Public Health, Office of Medical Marijuana staff

Application Fee Amount \$

Application Fee paid

Patient's Attestation Statement

By signing below, the Patient certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Medical Marijuana Patient Registry Card. If approved for the Registry Card, the Patient acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A.

To ensure confidentiality, information regarding application status will not be given over the phone.

* Once applications are processed, communication will be sent to the Patient's residence with further instructions for the finalization of the Registry Card.

* Applicants/patients are required by law to notify DPH Office of Medical Marijuana with any changes in information within 10 days of the change. Failure to do so can result in fines.

* Any registry card that is lost or stolen must be reported to DPH Office of Medical Marijuana immediately.

* Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued.



The last section of the application is the Patient's Attestation Statement. Read the statement and select the radio button to confirm each of the additional statements. Click '+Upload' to upload a copy of your identification. Once all sections are complete, review the application, sign/date the application and click 'Save' to save and transmit the application.

Patient's Attestation Statement

By signing below, the Patient certifies that the information on this application is complete, true, and submitted for the purpose of obtaining a State of Delaware Medical Marijuana Patient Registry Card. If approved for the Registry Card, the Patient acknowledges receipt of and agrees to the terms of the Delaware Medical Marijuana Act, Title 16 of the Delaware Code, Chapter 49A.

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<input type="checkbox"/>	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
<input type="checkbox"/>	I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
<input type="checkbox"/>	I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.
<input type="checkbox"/>	Did you include a legible copy of your Delaware driver's license or state-issued identification?

[+ Upload](#)

I understand that completing the signature block electronically constitutes a legal signature confirming that I acknowledge and agree to the above statement

Patient's Signature

MM-DD-YYYY

417 FEDERAL STREET, SUITE 130 - JESSE COOPER BUILDING - DOVER - DE - 19901 TELEPHONE 302-744-4749 - FAX 302-744-5366

Progress Notes

[Save](#)

