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

COMPASSIONATE USE PATIENT APPLICATION

Mail Completed Application to: Delaware Division of Public Health ATTN: MMP, Suite 140 417 Federal Street Dover, DE 19901	☐ New Patient	☐ Renewing Patient
	Have you ever applied for a Medical Marijuana Id card?	☐ Yes ☐ No

Print clearly. Incomplete applications may be denied. Denied applicants are required to wait six months before beginning the application process again. Application fees are non-refundable. ***Faxed and electronic copies of applications will not be accepted***.

PATIENT CONTACT INFORMATION

Name: ***(LAST, FIRST, M.I.)*** ☐ M ☐ F	**Date of Birth:** *(Must be 18 or Older)*
Address: *(Street)*	
Address: *(P.O. Box, Apt. #)*	
Address: *(City, State, ZIP Code)*	
Primary Phone:	☐ Check this box if a confidential message may be left at this number.
Secondary Phone:	☐ Check this box if a confidential message may be left at this number.
Email Address: *(Optional)*	☐ Check this box if confidential information may be shared by email.

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 Compassionate Use 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 (OMM) with any changes in information within 10 days of the change. Any registry card that is lost or stolen must be reported to OMM immediately. Failure to do so can result in fines.
* Patient information changes that are printed on the Registry Card (such as name or address) will require a new card issued.

_____ *initial*	I hereby certify that all the information provided on this application is true and accurate to the best of my knowledge.
_____ *initial*	I understand non-compliance with program requirements or lack of treatment efficacy will result in the termination of this card.
_____ *initial*	I acknowledge the Compassion Use Card is just one aspect in my comprehensive treatment plan and this card requires continued close monitoring with regularly scheduled follow-up appointments with my treatment team. I understand failure to continue follow-up appointments will result in suspension of my Compassion Use Card.
_____ *initial*	I consent to treatment with medical marijuana and I understand there is limited, or no evidence associated with medical marijuana's effectiveness in treating a condition that is not a debilitating medical condition listed in Title 16 of the Delaware Code, Chapter 49A.
_____ *initial*	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.

_____ Patient Signature	_____ Date of Signature

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.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Unmarried Partnership

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino

Race:
☐ Caucasian / White ☐ African American / Black
☐ Asian ☐ American Indian or Alaskan Native
☐ Native Hawaiian or Pacific Islander ☐ Other _____

Language:

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 _____

Veteran Status:

Are you a United States veteran?

☐ No ☐ Yes

Citizenship:

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

☐ No ☐ Yes

Education:

What is your highest level of education completed?

☐ Some High School Completed ☐ Technical School
☐ High School Diploma / GED ☐ University / 4-Yr College
☐ Community College / 2-Yr Degree ☐ Master Program or Above

Are you currently enrolled in school?

☐ No ☐ Yes, please specify: _____

Employment:

Are you currently employed?

☐ No ☐ Yes, part-time ☐ Yes, full-time

What is your current occupation? _____

Income:

What is your annual household income?

☐ Less than $19,999 ☐ $60,000 to $79,999
☐ $20,000 to $39,999 ☐ $80,000 to $99,999
☐ $40,000 to $59,999 ☐ $100,000 or above

Public Assistance:

Are you currently enrolled in a public assistance program such as food supplement program or any other?

☐ No ☐ Yes, please specify: _____

HEALTH CARE PRACTITIONER CERTIFICATION

PATIENT'S INSTRUCTIONS: Have your Health Care Practitioner complete this entire section. This section should be submitted with your completed application to the Medical Marijuana Program – partial applications will not be accepted. **The patient application must be received by the Division of Public Health Medical Marijuana Office, within 90 days of the Health Care Practitioner's signature date.**
Faxed and electronic copies will not be accepted.

NOTE: THIS DOES NOT CONSTITUTE A PRESCRIPTION FOR MARIJUANA.

HEALTH CARE PRACTITIONER'S INSTRUCTIONS: Print clearly and answer all the questions with information in the patient's medical record.

PATIENT INFORMATION

Name: *(Last, First, M.I.)* ☐ M ☐ F	**Date of Birth:** *(Must be 18 or Older)*

HEALTH CARE PRACTITIONER INFORMATION

Name: *(Title, First, MI, Last, Suffix)*		**Medical License Number:**
Address: *(Street)*		**License State:** *(Must be licensed in Delaware)*
Address: *(P.O. Box, Apt. #)*		**License Type:** *(MD, DO, APN, PA))*
Address: *(City, State, ZIP Code)*		
Phone:	**Fax:**	**Email:** *(not required)*
Medical Specialty: *(Oncology, Neurology, etc.)*		

MEDICAL CONDITION

Certifying Health Care Practitioner must evaluate the efficacy of medical marijuana treatment at the following intervals:
For substance use disorder diagnoses, re-evaluate after 15 days for the first 90 days, and every 30 days thereafter
For mental health disorder diagnoses, re-evaluate every 30 days --- For other conditions as per DPH/OMM
For autoimmune disease diagnoses, re-evaluate every 30 days for the first 90 days, and every 90 days thereafter

List the patient's severe medical condition:

What current standard care practices and treatments have been tried and have been found to be ineffective or their side effects are prohibitive for continued use?
(*Please provide progress notes or other documentation to support this question)*

What medical literature do you have supporting the potential benefit from using medical marijuana?
(Please provide documentation to support this question)

What other treatments are included in the patient's comprehensive treatment plan?
(*Documentation concerning comprehensive treatment plans MUST be submitted to the Medical Marijuana Program)*

HEALTH CARE PRACTITIONER CERTIFICATION (CONTINUED)

How will the certifying Health Care Practitioner monitor the overall response to the treatment plan?

(Documentation concerning monitoring MUST be submitted to the Medical Marijuana Program)

Does patient have a mental health diagnosis, how was this confirmed? How will mental health status be monitored? (*Please provide progress notes or other documentation to support this requisite)*

Health Care Practitioner MUST re-evaluate and document the efficacy of medical marijuana treatment and overall patient status as outlined above. Documents associated with reevaluation MUST be submitted to the Medical Marijuana Program every 90 days for the patient's Compassionate Use Card to remain active.

I have established a bona fide Health Care Practitioner-patient relationship with _____, (patient) beginning _____ (date of first patient visit to your office). This qualifying patient is under my care, either for primary care or the debilitating medical condition listed on this form	_____ *Health Care Practitioner Initials*
I completed an assessment of the qualifying patient's current medical condition, including presenting symptoms related to the debilitating medical condition I diagnosed or confirmed in accordance with Title 16, Chapter 49A of the Delaware Code (4902A(3).	_____ *Health Care Practitioner Initials*
I have completed an assessment of the qualifying patient's medical history, including medical records from other treating Health Care Practitioners for the qualifying condition. I have established a medical record of the qualifying patient with regards to the medical condition, continued treatment under my care, and will document follow-up to determine efficacy of the medical marijuana treatment.	_____ *Health Care Practitioner Initials*
All current standard care practices and treatments have been exhausted and have been ineffective or the side effects are prohibitive with continued use.	_____ *Health Care Practitioner Initials*
The Department of Health and Social Services (DHSS) requests your confirmation that medical marijuana is an appropriate treatment option to include a commitment to monitor patient closely.	_____ *Health Care Practitioner Initials*

Health Care Practitioner's Attestation

I _____, (Health Care Practitioner), hereby certify that I am a Health Care Practitioner duly licensed to practice medicine. It is my professional opinion that the qualifying patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's qualifying debilitating medical condition or symptoms associated with the debilitating medical condition. Further, it is my professional opinion that the potential benefits of the medical use of marijuana would likely outweigh the health risks for this patient.

I attest that the information provide in this written certification is true and correct.

_____ Health Care Practitioner's Signature (no signature stamps accepted)

_____ Date

Comments: Provide any additional information that would be useful in assessing this patient's application to the Delaware Medical Marijuana Program.

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 Health Care Practitioner(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. Faxed and electronic copies will not be accepted.

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:

_____, (Health Care Practitioner'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 in 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: _____.

_____ _____

Patient's Signature Date

PATIENT APPLICATION CHECKLIST

☐	**Did you initial all three of the Patient Attestation Statements and sign on the signature line? (Page 1)**
☐	**Did you include the Health Care Practitioner Certification forms completed and signed by your Health Care Practitioner? (Pages 3-4)**
☐	**Did you sign the Release of Medical Information form? (Page 5)**
☐	**Did you include Health Care Practitioners progress notes and supporting documentation from your visit?**
☐	**Did you include a legible copy of your Delaware driver's license or state-issued identification?**
☐	**Did you include the $50.00 non-refundable application fee or your signed Low-Income Charge Request form with supporting documentation? Please make check or money order payable to State of Delaware, MMP**

Medical Marijuana Compassionate Use Card

Delaware licensed Health Care Practitioners may now certify a patient with a serious debilitating medical condition who previously did not qualify for medical marijuana treatment under the Medical Marijuana Program, through the newly created "Compassionate Use Card" (CUC). The CUC is a card issued by the Department that authorizes the use of medical marijuana under specific conditions including:

- The patient has a severe and debilitating condition;
- All current standard care practices and treatments have been exhausted and have been ineffective, or the side effects are prohibitive with continued use;
- The certifying Health Care Practitioner will re-evaluate and document the efficacy of medical marijuana treatment (see the treatment re-evaluation schedule below);
- Use of medical marijuana must be part of a comprehensive treatment plan, especially for patients with substance use disorder;
- The Health Care Practitioner will provide scientific support the potential for the patient to benefit from using medical marijuana. The Department will review pertinent research articles or peer reviewed studies for evidence that medical marijuana may provide some benefit for the condition.

The Compassionate Use Card application can be found at:
https://dhss.delaware.gov/dhss/dph/hsp/medmaroc.html#annrpt

Marijuana may have serious unintended side effects that must be closely managed for patients with substance use disorder, emotional or mental health diagnoses. To that end, a Health Care Practitioner certifying a patient for a CUC will re-evaluate the efficacy of medical marijuana treatment at the following intervals:

Diagnoses	**Initial Re-evaluation**	**Re-evaluates in the First 90 Days**	**Continuing Re-evaluation**
Substance use disorder	after 15 days	every 15 days	every 30 days thereafter
Mental health disorder	after 30 days	every 30 days	every 30 days thereafter
Autoimmune disease	after 30 days	every 30 days	every 90 days thereafter
Other conditions	after 30 days	every 30 days	every 30 days, unless otherwise indicated or waived by the Department

The timeframe for re-evaluation begins on the date the card is issued.
The Health Care Practitioner certifying a patient for a compassionate use card may require the re-evaluation of the patient at shorter intervals than listed if appropriate.
Documentation for substance use disorder or mental health disorders can be from a certified mental health provider or substance abuse counselor.
Updated documentation of the re-evaluations for the compassionate use card must be transmitted to the Department by the certifying practice within five business days of the re-evaluation interval to prevent the compassionate use card from entering a suspension status.