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 PEDIATRIC APPLICATION

Mail Completed Application to: Delaware Division of Public Health ATTN: MMP, Suite 140 417 Federal Street Dover, DE 19901	☐ New Pediatric Patient	☐ Renewing Pediatric 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***.

PEDIATRIC (AGE 17 OR YOUNGER) PATIENT INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		

PRIMARY PARENT/GUARDIAN INFORMATION

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Secondary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Relationship to Applicant:		☐ Check this box if confidential information may be shared by email.
Email Address: ***(Optional)***		

SECONDARY PARENT/GUARDIAN INFORMATION (OPTIONAL – ONLY IF SECOND CAREGIVER CARD REQUIRED)

Name: *(Last, First, M.I.)*	☐ M ☐ F	**Date of Birth:**
Address: *(Street)*		
Address: *(City, State, ZIP Code)*		
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.
Secondary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ 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.
Relationship to Applicant:		

APPLICATION CHECKLIST

☐	**Did both guardians initial all three of the Attestation Statements and sign on the signature line? (Page 2)**
☐	**Did you include the Physician Certification forms completed and signed by the patient's physician? (Pages 4-5)**
☐	**Did the primary guardian sign the Release of Medical Information form? (Page 6)**
☐	**Did both guardians include a legible copy of their 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 PROGRAM KEY POINTS

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.

Patient Application Fee (registration effective for one year from issue date)	$	50.00
Patient Renewal Fee	$	50.00
Pediatric Patient Application Fee (includes parent/guardian fees)	$	50.00
Pediatric Patient Renewal Fee	$	50.00
Caregiver Application Fee	$	50.00
Caregiver Renewal Fee	$	50.00
Return Check Fee	$	35.00
Card Re-Issue Fee	$	20.00

PARENT/GUARDIAN'S ATTESTATION STATEMENT

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

* To ensure confidentiality, information regarding application status will not be given over the phone. Once applications are processed, communication will be sent to the Pediatric Patient's residence with further instructions for the finalization of the Registry Card.
* Parents/guardians of pediatric patients are required by law to notify DPH Office of Medical Marijuana with any changes in information (such as address, phone number, program eligibility, etc.) 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.

_____ *initial*	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
_____ *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.

_____ Parent/Guardian Signature	_____ Date of Signature

PARENT/GUARDIAN 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: _____

PEDIATRIC PHYSICIAN CERTIFICATION

PHYSICIAN'S INSTRUCTIONS: Print clearly and answer all of the questions with information in the patient's medical record. ***Attach copies of medical records showing diagnosis of patient's qualifying medical condition; underlying causes; previous treatments and their results; and treatment plans for the future.***

(A) PEDIATRIC PATIENT INFORMATION

Name: *(Last, First, M.I.)* ☐ M ☐ F	**Date of Birth:**

(B) PEDIATRIC PHYSICIAN INFORMATION (MUST be a pediatric neurologist, a pediatric gastroenterologist, a pediatric oncologist, a pediatric palliative care specialist, a Pediatric Psychiatrist, or a Developmental Pediatrician)

Name: *(Title, First, MI, Last, Suffix)*	**Medical License Number:**
Address: *(Street, Building, Suite #)*	**License State:** *(Must be licensed in Delaware)*
Address: *(City, State, ZIP Code)*	**License Type:** *(Must be DO or MD)*
Pediatric Specialty: ☐ Pediatric Neurologist ☐ Pediatric Gastroenterologist ☐ Pediatric Oncologist ☐ Pediatric Palliative Care Specialist ☐ Pediatric Psychiatrist ☐ Developmental Pediatrician	
Phone:	**Fax:** **Email:** *(not required)*

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 other treatments are included in the patient's comprehensive treatment plan?

(Documentation concerning comprehensive treatment plans MUST be submitted to the Medical Marijuana Program)

How will the certifying physician monitor the overall response to the treatment plan?

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

What medical literature do you have supporting the potential benefit from using medical marijuana?

(Please provide documentation to support this question)

Physician MUST re-evaluate and document the efficacy of medical marijuana treatment and overall patient status 30 days after the card issue date and every 90 days thereafter. Documents associated with the reevaulation MUST be submitted to the Medical Marijuana Program every 90 days for the patient's Compassionate Use Card to remain active.

PHYSICIAN CERTIFICATION (CONTINUED)

PHYSICIAN CERTIFICATION

I have established a bona fide physician-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

_____ *Physician 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).

_____ *Physician Initials*

I have completed an assessment of the qualifying patient's medical history, including medical records from other treating physicians 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.

_____ *Physician Initials*

I have explained the potential risks and benefits, as they are known to me, of the medical use of marijuana to the qualifying patient and parent/guardian.

_____ *Physician Initials*

All current standard care practices and treatments have been exhausted and have been ineffective or the side effects are prohibitive with continued use.

_____ *Physician 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.

_____ *Physician Initials*

Physician's Attestation

I _____, (physician), hereby certify that I am a physician 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.

_____ Physician'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

PARENT/GUARDIAN'S INSTRUCTIONS: Complete and sign the following release statement on behalf of the pediatric patient. This form will allow the Medical Marijuana Program staff to verify information with the certifying physician(s) relating to the 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.

PARENT/GUARDIAN RELEASE REQUEST

I _____, (parent/guardian), hereby authorize the Delaware Department of Health and Social Services (DHSS), Division of Public Health (DPH), Office of Medical Marijuana (OMM) to discuss my child's _____, (pediatric patient) medical condition, including treatment records, test results, and evaluations specific to _____, (patient's qualifying condition), with my child's certifying medical provider: _____, (pediatric 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 Office of Medical Marijuana, and that revocation may result in the inability of the program to certify my child 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.

The 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 child's eligibility for the Medical Marijuana Program.

By signing this release I certify that I am aware that the program may provide verification of my child's 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: _____.

_____ _____

Parent/Guardian's Signature Date

Medical Marijuana Compassionate Use Card

Delaware licensed physicians 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 physician 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 physician 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 physician 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 physician 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.