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

PEDIATRIC MEDICAL MARIJUANA PATIENT 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
	Application Fee Includes parent/guardian fees	1 year $50 2 year $75 3 year $100

Print clearly. Incomplete applications may be denied. Application fees are non-refundable. ***Faxed copies of applications will not be accepted***.

PEDIATRIC (AGE 17 OR YOUNGER) PATIENT INFORMATION		
Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ X	**Date of Birth:**
Address:		
Address: *(City, State, ZIP Code)*		

PRIMARY PARENT/GUARDIAN INFORMATION		
Name: *(Last, First, M.I.)*	☐ M ☐ F ☐ X	**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.
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 ☐ X	**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.
Email Address: *(Optional)*		☐ Check this box if confidential information may be shared by email.
Relationship to Applicant:		

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.

- 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 the information provided on this application is true and accurate to the best of my knowledge.
______ *initial*	I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
______ *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

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. **Low-Income Charge Request are valid for ONE YEAR CARDS ONLY**. 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.

		1yr	**2yr**	**3yr**
Patient Application Fee (registration effective for one year from issue date)	$	50.00	75.00	100.00
Pediatric Patient Application Fee (includes parent/guardian fees)	$	50.00	75.00	100.00
Card Re-Issue Fee	$	20.00		

APPLICATION CHECKLIST

☐	**Did both guardians initial all three of the Attestation Statements and sign on the signature line? (Page 2)**
☐	**Did you include the Health Care Practitioner Certification forms completed and signed by the patient's Health Care Practitioner? (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 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**

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 HEALTH CARE PRACTITIONER CERTIFICATION

PATIENT'S INSTRUCTIONS: The patient's pediatric specialty Health Care Practitioner will complete this entire section. Only a pediatric neurologist, a pediatric gastroenterologist, a pediatric oncologist, or a pediatric palliative are specialist can certify for patients aged 17 and under.

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.*

PEDIATRIC HEALTH CARE PRACTITIONER 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:** *(MD, DO, APN, PA)*
Pediatric Specialty:		
Phone:	**Fax:**	**Email:** *(not required)*

Health Care Practitioner Identified Medical Condition(s) for Pediatric Patients:

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

HEALTH CARE PRACTITIONER CERTIFICATION (CONTINUED)

HEALTH CARE PRACTITIONER CERTIFICATION

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 patient is likely to receive therapeutic or palliative benefit from the medical use of marijuana to treat or alleviate the patient's medical condition or symptoms associated with the 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.

I have established a bona fide Health Care Practitioner-patient relationship

I completed an assessment of the patient's current medical condition, including presenting symptoms related to the medical condition I diagnosed or confirmed in accordance with Title 16, Chapter 49A of the Delaware Code (4902A(3).

I have completed an assessment of the patient's medical history, including medical records from other treating Health Care Practitioners for the condition. I have established a medical record of the 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.

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

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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.

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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 Health Care Practitioner(s) relating to the 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 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 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