Medical Marijuana Compassionate Need Program

PRIME WELLNESS OF CONNECTICUT

MMJ Compassionate Need Program Application

Identification Information

Patient Name: _____

Home Address: _____

_____

Phone Number / Email:

CT MMP Card Number: _____

Financial Documentation Submitted: (Check Applicable)

☐ Recent Tax Return ☐ Unemployment Income ☐ Current Pay Stub

☐ Soc Sec Income ☐ Retirement/Annuity Inc ☐ Disability Income

☐ Title 19 Income ☐ Workers Comp Income ☐ Under 18 years old

Total Number of People in Your Household: _____

Household Total Income: _____

Patient Agreement

I attest that the financial information and documentation I provided is accurate. I understand that if this information is determined to be false, my enrollment in the Compassionate Need Program will be terminated. I understand that if it is determined that my income exceeds the eligibility standard of 200% of the federal poverty level (FPL) adjusted for family size, I will not be enrolled in the Compassionate Need Program. I understand that as an enrollee of the Compassionate Need Program I will be eligible for discounts on the medical marijuana I purchase up to the total patient allotment per month. I agree that any purchase of medical marijuana is for my personal use only and I will abide by the legal requirements of the State MMJ program.

Patient Signature: *Application Date:*

_____

Manager Approval

☐ Approved ☐ At or below 200% FPL (Gross Income)

☐ Denied Reason : _____

Manager Signature: *Approval Date:*

Enrollment in the Compassionate Need Program is approved for a one-year period from the approval date of the application and is subject to a one-time application fee of $25.