#  COMPASSIONATE CARE PROGRAM

#  *Montville: Financial Hardship Application*

## Identification Information

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| --- | --- |
| Patient Name: | Date of Birth: / /  |
| Phone: |  |
| Email: |   |

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| **Supporting Documentation to be provided to Dispensary Pharmacist:** |
| **Federal Tax Return:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ W-2:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Social Security Award Notice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Disability Award Notice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Unemployment Award Notice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ TANF or SNAP Program Statement:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  |

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| **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 Care 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 Care Program. I understand that as an enrollee of the Compassionate Care 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:* |

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**\*\*\*For Office Use Only\*\*\***

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|   | ☐ | Approved ☐ Denied \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |   |  |
|  |  |  |  |

 Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Approval Date: \_\_\_\_\_\_\_\_\_\_\_

COMPASSIONATE CARE PROGRAM

**To Qualify:**

* Must have current MMP registration and be a patient of The Botanist (in Montville, Connecticut), AND
* Must prove low-income eligibility at or below 200% of the Federal Poverty Level

**Income Guidelines:**

 Persons in Family/Household 2020 Income Limit

1. $ 24,980
2. $ 33,820
3. $ 42,660
4. $ 51,500
5. $ 60,340
6. $ 69,180
7. $ 78,020

**To Enroll:**

* Must complete application
* Must show proof of annual household income and size. Household income should give an accurate representation of income, based on all persons in the household.

**Discount Amount:**

* 25% Off 3 Items of your choice each calendar month.
* Patients who qualify for CCP may be eligible for Compassionate Care items

NOTE: On occasion, MMJ producers will donate a limited supply of items, so please inquire about product availability at the time of purchase. Typically, donated products arrive the first or second week of each month. Patients will be eligible to select an item of their choice every-other-month.

* Maximum promotional discounts will be allowed but cannot be combined with other additional discounts (i.e. veteran status; dispensary sales)

**Program Approval:**

* Approval and / or continued participation is at the sole discretion of The Botanist
* The Botanist reserves the right to deny an applicant or to terminate an enrollee to safeguard against diversion or any illegal or improper use of this program.