Oregon Medical Marijuana Program

http://www.healthoregon.org/mm

APPLICATION FORM and FEE WORKSHEET

OMMP FEES ARE NON-REFUNDABLE

APPLICATION FEE WORKSHEET

QUESTION 1 – Are you going to list yourself as your own grower?

- ☐ YES Go to Question 2
- ☐ NO Go to Question 2

QUESTION 2 - Are you currently receiving benefits from OHP[1] or SNAP[2] or SSI[3]?

- ☐ YES If YES, go to Question 3
- ☐ NO If NO, AND you answered "YES" to Question 1, **your fee is $200**
  If NO, AND you answered "NO" to Question 1, **your fee is $250 and you must designate a grower.**

QUESTION 3 - Are you an Oregon resident currently receiving benefits from OHP[1] or SNAP[2]?

- ☐ YES If YES, AND you answered "YES" to Question 1, **your fee is $100**
  If YES, AND you answered "NO" to Question 1, **your fee is $150 and you must designate a grower.**
- ☐ NO **or** YES AND you are receiving SSI[3] benefits, go to Question 4

QUESTION 4 - Are you currently receiving benefits from SSI[3]?

- ☐ YES AND you answered "YES" to Question 1, **your fee is $20**
  AND you answered "NO" to Question 1, **your fee is $70 and you must designate a grower.**

MINORS

If the applicant is a minor (under age 18), the custodial parent or legal guardian with responsibility for health care decisions must submit a notarized declaration and be listed as the Caregiver on the application.

CRIMINAL HISTORY CHECK

According to ORS 475.304(6)(a), the Authority shall conduct a criminal records check under ORS 181.534 of any person whose name is submitted as a Grower.

Complete the application on the reverse side, include Attending Physician's Statement, identification copies, check or money order, and mail to:

OHA/OMMP
PO BOX 14450
Portland, OR 97293-0450

If you have any questions or if you need this document in an alternative format, please contact the OMMP at 971-673-1234. Phone hours are Monday through Friday 11 am to 4:45 pm.

[1] OHP: To qualify for a reduced fee, a copy of current proof of the patient's Oregon Health Plan eligibility must be provided at the time the patient submits an application.

[2] SNAP/Food Stamps: To qualify for the reduced fee, a copy of current proof of the patient's SNAP Food Stamp benefit must be provided at the time the patient submits an application.

[3] SSI: To qualify for a reduced fee, a copy of Supplemental Security Income monthly benefit receipt or eligibility for the current year must be provided at the time the patient submits an application. **Social Security Disability Income (SSDI) and Social Security Retirement receipt *do not qualify* for a reduced application fee.**

Until this application has been approved or denied by the Oregon Medical Marijuana Program, a copy of these materials (along with proof of mailing or transmission) shall have the same legal effect as a registration card. ORS 475.309(9)

The Oregon Medical Marijuana Act neither protects marijuana plants from seizure nor individuals from prosecution if the federal government chooses to take action against patients or caregivers under the federal Controlled Substances Act.

Do Not Fax

Oregon Medical Marijuana Program
http://www.healthoregon.org/mm

APPLICATION FORM

Complete all sections marked **REQUIRED**.
Please type or print legibly.
Do not alter this form or use white out.

OFFICIAL USE ONLY

CHC ☐ FS ☐ OHP ☐ SSI ☐

REQUIRED PATIENT INFORMATION

LEGAL NAME (LAST, FIRST, M.I.):	☐ Male	☐ Female	DATE OF BIRTH:
MAILING ADDRESS:			PHONE #:
CITY: STATE: ZIP CODE:			COUNTY:

Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box:
[ ] OR DL / ID #: _____ **[ ]** Other US State or Federal Issued ID#: _____

OPTIONAL CAREGIVER INFORMATION (*Not your physician)*

LEGAL NAME (LAST, FIRST, M.I.):	☐ Male	☐ Female	DATE OF BIRTH:
MAILING ADDRESS:			PHONE #:
CITY: STATE: ZIP CODE:			COUNTY:

Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box:
[ ] OR DL / ID #: _____ **[ ]** Other US State or Federal Issued ID #: _____

REQUIRED GROWER INFORMATION

LEGAL NAME (LAST, FIRST, M.I.):	☐ Male	☐ Female	DATE OF BIRTH:
MAILING ADDRESS:			PHONE #:
CITY: STATE: ZIP CODE:			COUNTY:

Photo Identification: A photocopy of one of the current following ID types must be attached. Please check appropriate box:
[ ] OR DL / ID #: _____ **[ ]** Other US State or Federal Issued ID #: _____

REQUIRED GROWSITE INFORMATION

PHYSICAL ADDRESS:		
CITY: **OREGON**	ZIP CODE:	
COUNTY:		

REQUIRED APPLICATION and GROWSITE REGISTRATION FEE

☐ Patient who is own grower - $200	☐ Patient who is own grower **and** current OHP or SNAP participant - $100	☐ Patient who is own grower **and** current SSI participant - $20
☐ Patient with designated grower - $250	☐ Patient with designated grower **and** current OHP or SNAP participant- $150	☐ Patient with designated grower **and** current SSI participant - $70

*****OMMP FEES ARE NON-REFUNDABLE*****

Enclose your check or money order payable to "OMMP" or "OHA/State of Oregon". Please indicate on your check or money order who the payment is for. We do not accept debit/credit cards. This form must accompany payment. Do not staple or paperclip attachments. See opposite side for additional fee information.

REQUIRED SIGNATURE & DATE

I TESTIFY THAT THE ABOVE INFORMATION IS TRUE.

APPLICANT SIGNATURE:	DATE:

Do Not Fax

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