PRIME WELLNESS
OF CONNECTICUT

Medical Marijuana Compassionate Need Program

2019 Compassionate Need Program Application

Identification Information

Patient Name: _____

Home Address: _____

_____

Phone: _____

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 Annual Income: _____ Total Members of Household: _____

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:*

_____

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.

Manager Approval

☐ Approved ☐ Denied _____

Manager Signature: _____ Approval Date: _____

Docs:

Fee:

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Compassionate Need Discount Program 2019

Discount Amount:

- 10% off of the patient's total MMP allotment per month.
- 10% off of all other accessories or products.
- Maximum promotional discounts will be allowed but cannot be combined with other additional discounts (i.e. veteran status; dispensary sales)

To Qualify:

- Must have current MMP registration and be a patient of Prime Wellness of CT, AND
- Must prove low income eligibility at or below 200% of the Federal Poverty Level OR
- Must be a Military Veteran (with poof of status – VA/Military ID card or DD214) OR
- Must be a patient 65 years of age or older OR under 18 years of age. (No income documents required).

To Enroll:

- Must submit completed application
- Must submit a one-time $25 (cash or debit) non-refundable fee
- Must provide proof of annual household income and size

- Most Recent Tax Return
- Workers Comp Proof
- Retirement / Annuity Income
- Current Pay Stub
- Unemployment Income
- Title 19 / Medicaid Income
- Disability Income
- Social Security Income

Income Guidelines:

Persons in Family/Household	2019 Income Limit
1	$ 24,280
2	$ 32,920
3	$ 41,560
4	$ 50,200
5	$ 58,840
6	$ 67,480

Program Approval:

- Approval and / or continued participation is at the sole discretion of PWCT
- Patient must submit a $25.00 non-refundable, one time application processing fee, prior to approval.
- Participants must provide updated income documents annually.
- PWCT 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.