MMJ Compassionate Need Discount Program

Discount Amount:

10% off of the patient's total MMP allotment per month. 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 Still River Wellness AND Must be 65 years of age or older OR Must be a Military Veteran (with poof of status – VA/Military ID card or DD214) OR Must prove low income eligibility at or below 200% of the Federal Poverty Level OR Must be a patient under 18 years of age. (No income documents required).

To Enroll:

Must submit completed application. Must provide proof of annual household income and size and Most Recent Tax Return, Social Security Income, Disability Income, Title 19 / Medicaid Income, Unemployment Income, Worker's Compensation Income, Retirement / Annuity Income, Current Paystubs (1 month)

Income Guidelines:

Persons in Family/Household	Income Limit
1	$ 24,280
2	$ 32,920
3	$ 41,560
4	$ 50,200
5	$ 58,840
6	$ 67,480
7	$ 76,120
8	$ 84,760

Program Approval:

Approval and / or continued participation is at the sole discretion of the Still River Wellness Members. Participants must provide updated income documents annually. Still River Wellness 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.

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