Arizona Medical Marijuana Qualifying Patient Application Form

Patient Information:

First Name_____ Middle Initial____ Last_____ Suffix____

Birthdate (mm/dd/yyyy): _____/_____/_____ Gender: Male Female

ID Type (circle one): Driver's LicenseUS Passport Identification Card

ID Number: _____ Issued Date: _____

Residence Address:

_____

City _____ Zip _____County_____

Phone Number (_____) _____ Email _____

Mailing Address:

___ Check if mailing address is the same as residential.

Address_____

City_____ Zip _____County _____

Billing Information:

____Check if billing address is the same as residential.

Debit or Credit Card (Visa or Mastercard): _____

Expiration Date: _____ **CSV (3 digits on back of card next to signature line):** _____

Billing First Name _____ Billing Last Name _____

Billing Address _____

City _____ State _____ Zip _____

Request to Cultivate: (must reside outside 25 mile radius of any dispensary to cultivate)

__ Check if patient is requesting to cultivate
__ Check if designated caregiver is requesting to cultivate
__ Check if not requesting to cultivate

If denied cultivation status, would you like us to file without requesting to cultivate? YES or NO

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Caregiver Information: (A designated person that can legally purchase on your behalf. **Additional $200 fee and forms submitted to AZDHS.** Please refer to the Designated Caregiver Application Information.)
First Name_____ Middle_____ Last_____ Suffix_____
Birthdate (mm/dd/yyyy): _____/_____/_____ Gender: Male Female
Address _____
City _____ Zip _____State _____

Initial below after reading the following statement:

____ I am aware that there are numerous legal challenges to the Arizona Medical Marijuana Act (AMMA). If the AMMA were ever to be overturned, there are no refunds for this application fee to the AZDHS.

___ Check if you qualify for the SNAP Discount

If you are eligible for SNAP assistance and proper documentation is provided, your application fee will be reduced from $150 to $75. You will be required to upload a document showing that you are currently eligible for SNAP benefits. This document must have the patient's name on it (such as your card with your name on it or your acceptance of benefits letter). **SNAP cards without the name of the patient applying will not be accepted as proof of current SNAP benefits.**

I, _____, understand and agree that the information provided above will only be used to complete the Arizona Medical Marijuana Qualifying Patient Renewal Application online to the AZ Department of Health Services website.

_____ _____

Signature Date