



The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Bureau of Health Care Safety and Quality
Medical Use of Marijuana Program
99 Chauncy Street, 11th Floor, Boston, MA 02111

CHARLES D. BAKER
Governor

KARYN E. POLITO
Lieutenant Governor

MARYLOU SUDDERS
Secretary

MONICA BHAREL, MD, MPH
Commissioner

Tel: 617-660-5378
www.mass.gov/medicalmarijuana

APPLICATION OF INTENT
Request for a Certificate of Registration to
Operate a Registered Marijuana Dispensary

INSTRUCTIONS

This application form is to be completed by any non-profit corporation that wishes to apply for a Certificate of Registration to operate a Registered Marijuana Dispensary ("RMD") in Massachusetts.

If seeking a Certificate of Registration for more than one RMD, the applicant non-profit corporation ("Corporation") must submit a separate *Application of Intent*, all required attachments, and an application fee for each proposed RMD. Please identify each application of multiple applications by designating it as Application 1, 2 or 3 in the header of each application page. Please note that no executive, member, or any entity owned or controlled by such an executive or member, may directly or indirectly control more than three RMDs.

However, even if submitting an *Application of Intent* for more than one RMD, an applicant need only submit one *Character and Competency form* for each required individual.

Unless indicated otherwise, all responses must be typed into the application forms. Handwritten responses will not be accepted. Please note that character limits include spaces.

Attachments should be labelled or marked so as to identify the question to which it relates.

Each submitted application must be a complete, collated response, printed single-sided, and secured with a binder clip (no ring binders, spiral binding, staples, or folders).

Mail or hand-deliver the *Application of Intent*, with all required attachments, the \$1,500 application fee, and Remittance Form to:

Department of Public Health
Medical Use of Marijuana Program
RMD Applications
99 Chauncy Street, 11th Floor
Boston, MA 02111

RECEIVED

JULY 29 2015

MA Dept. of Public Health
99 Chauncy Street
Boston, MA 02111

Application fees are non-refundable and non-transferable.

REVIEW

Applications are reviewed in the order they are received.

After a completed application packet and fee is received by the Department of Public Health ("Department"), the Department will review the information and will contact the applicant if clarifications/updates to the submitted application materials are needed. The Department will notify the applicant whether they have met the standards necessary to be invited to submit a *Management and Operations Profile*.

If invited by the Department to submit a *Management and Operations Profile*, the applicant must submit the *Management and Operations Profile* within 45 days from the date of the invitation letter, or the applicant must submit a new *Application of Intent* and fee.

PROVISIONAL CERTIFICATE OF REGISTRATION

Applicants have one year from the date of the submission of the *Management and Operations Profile* to receive a Provisional Certificate of Registration. If an applicant does not receive a Provisional Certificate of Registration after one year, the applicant must submit a new *Application of Intent* and fee.

REGULATIONS

For complete information regarding registration of an RMD, please refer to 105 CMR 725.100.

It is the applicant's responsibility to ensure that all responses are consistent with the requirements of 105 CMR 725.000, et seq., and any requirements specified by the Department, as applicable.

PUBLIC RECORDS

Please note that all application responses, including all attachments, will be subject to release pursuant to a public records request, as redacted pursuant to the requirements at M.G.L. c. 4, § 7(26).

QUESTIONS

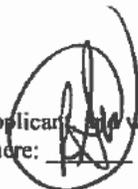
If additional information is needed regarding the RMD application process, please contact the Medical Use of Marijuana Program at 617-660-5370 or RMDapplication@state.ma.us.

Information on this page has been reviewed by the applicant and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: 

CHECKLIST

The forms and documents listed below must accompany each application, and be submitted as outlined above:

- A fully and properly completed *Application of Intent*, signed by an authorized signatory of the corporation
- A copy of the Corporation's *Certificate of Legal Existence* from the Massachusetts Secretary of State
- Financial account summary(ies) (as outlined in Section D)
- A bank or cashier's check made payable to the *Commonwealth of Massachusetts* for \$1,500.
- A completed *Remittance Form* (use template provided)
- A completed and signed *Character and Competency* form (use template provided) for each of the following actors:
 - Chief Executive Officer; Chief Operating Officer; Chief Financial Officer; individual/entity responsible for marijuana for medical use cultivation operations; individual/entity responsible for the RMD security plan and security operations; each member of the Board of Directors; each Member of the Corporation, if any; and each person and entity known to date that is committed to contributing 5% or more of initial capital to operate the proposed RMD. For entities contributing initial capital to operate the proposed RMD, the *Character and Competency* Form must be completed and signed by the entity's Chief Executive Officer/Executive Director and President/Chair of the Board of Directors.

Information on this page has been reviewed by the applicant, and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: 

Application 2 of 3 Applicant Non-Profit Corporation Commonwealth Alternative Care

SECTION A. APPLICANT INFORMATION

1. Commonwealth Alternative Care Inc
Legal name of Corporation
2. Robert Schnibbe, Jr.
Name of Corporation's Chief Executive Officer
3. 987 Tremont Street
Duxbury, MA 02332
Address of Corporation (Street, City/Town, Zip Code)
4. Robert Schnibbe, Jr.
Applicant point of contact (name of person the Department should contact regarding this application)
5. 617-312-6143
Applicant point of contact's telephone number
6. bschnibbe@commonwealthaltcare.org
Applicant point of contact's e-mail address
7. Number of applications: How many *Applications of Intent* do you intend to submit? 3

SECTION B. INCORPORATION

8. Attach a *Certificate of Legal Existence* from the Massachusetts Secretary of State, documenting that the applicant non-profit entity is incorporated as a non-profit in Massachusetts.

SECTION C. CHARACTER AND COMPETENCY

9. Attach a *Character and Competency* form (use template provided) for each of the following actors:
 - The Chief Executive Officer; Chief Operating Officer; Chief Financial Officer; individual/entity responsible for marijuana for medical use cultivation operations; individual/entity responsible for the RMD security plan and security operations; each member of the Board of Directors; each Member of the Corporation, if any; and each person and entity known to date that is committed to contributing 5% or more of initial capital to operate the proposed RMD. For entities contributing initial capital to operate the proposed RMD, the *Character and Competency* Form must be completed and signed by the entity's Chief Executive Officer/Executive Director and President/Chair of the Board of Directors.

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Application 2 of 3 Applicant Non-Profit Corporation _____

SECTION D. INITIAL CAPITAL REQUIREMENT

Describe the sources, types, and amounts of required initial capital in the table below, showing that the Corporation has at least \$500,000 in its control and available for this *Application of Intent* and at least \$400,000 in its control and available for each additional *Application of Intent*, if any, as evidenced by bank statements, lines of credit, or financial institution statements. Add more tables if needed.

If the required funds are being held in an account in the name of an individual or entity other than the Corporation, the individual or authorized signatory of the entity must provide their signature in the "Signature of Account Holder" column. Their signature below indicates that they are committing the amount of their funds identified in the table to the applicant.

In addition to completing this table, submit a one-page financial account summary for each account listed below documenting the available funds, dated no earlier than 30 days prior to the date the *Application of Intent* was submitted to the Department.

Name on Account	Financial Institution	Type of Account	Amount	Signature of Account Holder
Casey Griffin	SCS Financial	Investment Account	\$ 800,000.00	<i>Casey M Griffin</i>
Connor McCaffery Laura McCaffery	Chase	Better Banking Checking	\$ 500,000.00	<i>[Signature]</i> <i>L McCaffery</i>
		TOTAL:	\$ 1,300,000.00	—

Information on this page has been reviewed by the applicant and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: *[Signature]*



SCS FINANCIAL
Strategic Capital Solutions

June 26, 2015

Massachusetts Department of Public Health

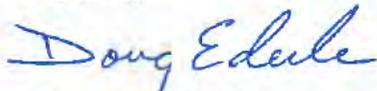
RE: Proof of Funds

To Whom It May Concern,

SCS Financial Services, LLC currently serves as investment advisor to Casey Griffin and we have been her advisor for ten years. Please accept this letter as confirmation that said client currently has access to accounts with assets greater than \$800,000.

If you have any questions, please contact Doug Ederle at (617) 204-6444 or Chris Stone at (617) 204-6410.

Regards,


Douglas R. Ederle
SCS Financial Services, LLC

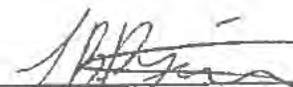
Cc: Chris Stone

**COMMONWEALTH OF MASSACHUSETTS
SUFFOLK COUNTY**

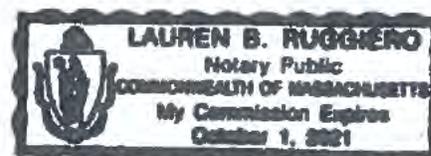
Then personally appeared the within named Douglas R. Ederle and acknowledged the foregoing to be his/her free act and deed.

Before me,





Notary Public







Deposit Account Balance Summary

06/26/2015

Requestor information:

LAURA MCCAFFERY



Summary of Deposit Account				
Account Number	Account Type	Open Date	Current Balance	Avg Balance (12 mos)
[REDACTED]	[REDACTED]	[REDACTED]	\$1,420,317.11	[REDACTED]
Customer Information				
CONNOR MCCAFFERY		Primary Joint Or		
LAURA MCCAFFERY		Secondary Joint Or		

Deposit Account Balance Summary request completed by:

SOPHIE MELOUDIS
(847) 835-8507
Hubbard Woods

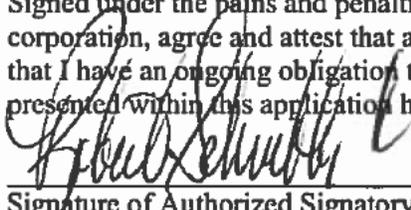
PLEASE NOTE THAT THE INFORMATION PROVIDED IN THIS LETTER WILL BE THE ONLY INFORMATION RELEASED BY JPMorgan Chase, N.A.

This letter is written as a matter of business courtesy, without prejudice, and is intended for the confidential use of the addressee only. No consideration has been paid or received for the issuance of this letter. The sources and contents of this letter are not to be divulged and no responsibility is to attach to this bank or any of its officers, employees or agents by the issuance or contents of the letter which is provided in good faith and in reliance upon the assurances of confidentiality provided to this bank. Information and expressions of opinion of any type contained herein are obtained from the records of this bank or other sources deemed reliable, without independent investigation, but such information and expressions are subject to change without notice and no representation or warranty as to the accuracy of such information or the reliability of the sources is made or implied or vouched in any way. This letter is not to be reproduced, used in any advertisement or in any way whatsoever except as represented to this bank. This bank does not undertake to notify of any changes in the information contained in this letter. Any reliance is at the sole risk of the addressee.

Application 2 of 3 Applicant Non-Profit Corporation Commonwealth Alternative Care

ATTESTATIONS

Signed under the pains and penalties of perjury, I, the authorized signatory for the applicant non-profit corporation, agree and attest that all information included in this application is complete and accurate and that I have an ongoing obligation to submit updated information to the Department if the information presented within this application has changed.


Signature of Authorized Signatory

06/25/2015
Date Signed

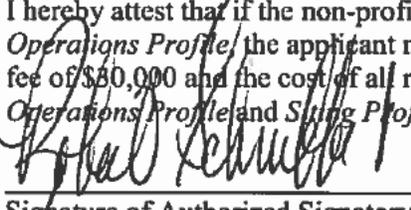
Robert Schnibbe, Jr.

Print Name of Authorized Signatory

Chief Executive Officer

Title of Authorized Signatory

I hereby attest that if the non-profit corporation is allowed to proceed to submit a *Management and Operations Profile* the applicant non-profit corporation is prepared to pay a non-refundable application fee of \$80,000 and the cost of all required background checks, and comply with all *Management and Operations Profile* and *Staff Profile* requirements.


Signature of Authorized Signatory

06/25/2015
Date Signed

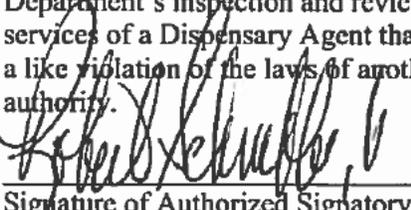
Robert Schnibbe, Jr.

Print Name of Authorized Signatory

Chief Executive Officer

Title of Authorized Signatory

I hereby attest that I understand that registered marijuana dispensaries are required to conduct background investigations of proposed Dispensary Agents, that such background investigations are subject to the Department's inspection and review, and that the applicant non-profit corporation will not engage the services of a Dispensary Agent that has ever been convicted of a felony drug offense in Massachusetts, or a like violation of the laws of another state, the United States, or a military, territorial, or Indian tribal authority.


Signature of Authorized Signatory

06/25/2015
Date Signed

Robert Schnibbe, Jr.

Print Name of Authorized Signatory

Chief Executive Officer

Title of Authorized Signatory

Information on this page has been reviewed by the applicant and where provided by the applicant, is accurate and complete, as indicated by the initials of the authorized signatory here: 



William Francis Galvin
Secretary of the
Commonwealth

The Commonwealth of Massachusetts
Secretary of the Commonwealth
State House, Boston, Massachusetts 02133

Date: June 16, 2015

To Whom It May Concern :

I hereby certify that

COMMONWEALTH ALTERNATIVE CARE INC.

appears by the records of this office to have been incorporated under the General Laws of this

Commonwealth on **April 20, 2015** (Chapter 180).

I also certify that so far as appears of record here, said corporation still has legal existence.



In testimony of which,
I have hereunto affixed the
Great Seal of the Commonwealth
on the date first above written.

William Francis Galvin

Secretary of the Commonwealth

Certificate Number: 15063793240

Verify this Certificate at: <http://corp.sec.state.ma.us/CorpWeb/Certificates/Verify.aspx>

Processed by: tgr

A handwritten signature in black ink, appearing to be "tgr", enclosed in a circular scribble.

Corporations Division

Secretary of the Commonwealth of Massachusetts

Certificate Request Form

ID Number	Entity name	Select a certificate type	E-mail delivery
001169869	COMMONWEALTH ALTERNATIVE CARE INC.	Legal Existence	<input checked="" type="checkbox"/>

Fee:

\$ 7.00

Note: An expedited service fee will be added when this request is completed

Expedited fee:

\$ 3.00

Special filing instructions: Enter any details that apply to this request

Filer's contact information: complete all required (*) boxes:

- * Contact name: Andrea F. Nuciforo Jr.
- Business name: Nuciforo Law Group
- * Mailing address: 100 North Street
- Additional address detail: Suite 405
- * City, State, Zip code: Pittsfield MA 01201
- Country: UNITED STATES
- Contact phone number: 4135535515 Extension: 101
- * Contact e-mail address: anuciforo@nuciforo.com

Providing an email address allows the Corporations Division to contact you quickly if your filing is rejected.

