Cannabis Control Commission
COMMONWEALTH OF MASSACHUSETTS

Medical Use of Marijuana Program: Patient Fee Waiver Application

To possess marijuana for medical purposes, a qualifying patient must register with the Medical Use of Marijuana Program (Program) by submitting a registration form along with a $50 annual registration fee. However, you may be qualified for a waiver of the $50 annual registration fee if you have a verified financial hardship.

You are considered to have a verified financial hardship if you are a current recipient of MassHealth, Supplemental Security Income (SSI), the Supplemental Nutrition Assistance Program (SNAP), or your income does not exceed 300% of the federal poverty level (see table on next page).

This fee waiver application form is for use by qualifying patients who do not have access to the internet and are unable to apply for a fee waiver online. To apply for a waiver of the registration fee, complete and mail in the attached Fee Waiver Application Form along with proof of verified financial hardship.

Preparing to Apply

Before filling out the attached Fee Waiver Application Form, you will need to gather the following item:

- A **copy** of proof of verified financial hardship (as explained below)

Proof of Verified Financial Hardship

*Proof of verified financial hardship includes a **copy** of one of the following:*

- Official MassHealth acceptance letter for the current year, or official MassHealth redetermination letter for the current year **(we do not accept MassHealth Managed Care or official MassHealth cards)**;
- SSI benefit verification letter for the current year (Social Security Disability Insurance benefit does not qualify);
- State or federal tax return from this year or last year, including all attachments; *or*
- SNAP Electronic Benefit Transfer (EBT) statement from the current year (submitting your Department of Transitional Assistance card is not sufficient documentation for a fee waiver approval).

300% of Federal Poverty Level

Family Size	Annual Income
1	$37,470
2	$50,730
3	$63,990
4	$77,250
5	$90,510
6	$103,770
7	$117,030
8	$130,290
Each Additional	$13,260

From the U.S. Department of Health & Human Services
2019 Poverty Guidelines

Application Process

Complete all required sections of the Fee Waiver Application Form neatly and accurately. If you make a mistake on the form, please complete a new form.

Incomplete applications or applications that are not signed and dated, or are not readable, will not be processed and will be returned to the applicant.

Submitting Your Fee Waiver Application Form

Mail your:

- Completed Fee Waiver Application form; *and*
- Copy of proof of verified financial hardship

To:

Cannabis Control Commission
Medical Use of Marijuana Program
101 Federal Street, 13th Floor
Boston, MA 02110

Once your application has been received and processed by the Program, you will be contacted regarding the status of your fee waiver application. If an email address was provided, you will receive a notification regarding the status of your fee waiver application via email.

If your application for a fee waiver is not approved, you will need to submit a $50 registration fee to become registered with the Program.

Registration Renewals

Fee waivers expire annually. You may re-apply for a fee waiver, on an annual basis, up to 60 days before the date that your fee waiver expires by following the instructions outlined above.

Questions

Should you have questions about the fee waiver application process, please contact the Program at 833-869-6820.

FEE WAIVER APPLICATION FORM

(Please Print)

SECTION A: PATIENT INFORMATION (REQUIRED)

The information in Section A must match the information submitted on your Patient Registration Form.

1. Last name:	2. First name:	Middle initial:
3. Date of birth (mm/dd/yyyy): / /	4. Phone number: ( )	
5. Email address:		

RESIDENTIAL ADDRESS OF PATIENT (REQUIRED)

6a. Residential address of patient:	6b. Residential address 2:	
7. City:	8. State: MA	9. Zip Code:

MAILING ADDRESS OF PATIENT (IF DIFFERENT FROM RESIDENTIAL ADDRESS)

10a. Address 1:	10b. Address 2:	
11. City:	12. State:	13. Zip Code:

SECTION B: FINANCIAL INFORMATION (REQUIRED)

Please mark all that apply.

14. I am currently a recipient of MassHealth. I have enclosed a copy of my official MassHealth acceptance letter from the current year or my official MassHealth redetermination letter from the current year. ❑
    MassHealth member identification number: _____
15. I am currently receiving Supplemental Security Income. I have enclosed a copy of my Supplemental Security Income benefit verification letter for the current year. ❑
16. I am currently a participant in the Supplemental Nutrition Assistance Program (SNAP). I have enclosed a copy of my SNAP statement from the current year. ❑
17. I have enclosed a copy of my complete State or Federal tax return from this year or last year. ❑

SECTION C: PATIENT ATTESTATION (REQUIRED)

By signing below, I hereby certify that the above information is correct and complete.

18. Patient signature:	19. Date signed (mm/dd/yyyy): / /