SESPE CREEK

Compassionate Care Program Application

Application Date:_____

☐ First Time Applicant

☐ Renewal

☐ Free Medicinal Product Program

☐ Discount Only Program

Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Email: _____

Primary Phone #: (_____)_____-_____

Registered Member at Sespe Creek since (mm/yy): ___ /____

Marital Status: Single

Monthly Income:_____ Monthly Expenses:_____

Number of people living in household: _____ Are you a dependent: Yes

Number of dependents in household: _____ Are you the head of household: Yes

---

Medical Recommendation #:_____

Recomending Physician:_____

Issue Date:_____ Expiration Date:_____

Phone/Email/Website:_____

***To participate in the free medicinal cannabis program, applicants must include a copy of their current medical recommendation. Applicants without a current medical recommendation are unable to receive free medicinal cannabis per California Law, however they may be eligible for our Compassionate Care Discount.

In order to qualify for the program, <u>you must provide proof</u> of the following three requirements: *(Applications with incomplete or missing information may be denied or we may ask you for more information.)*

1. **RESIDENCY:** Copy of utility bill or lease in your name showing a Ventura County address; or a current Driver's License with a Ventura County address. Applicant must be a registered member for at least 60 days prior to application.
   **Check to confirm document is attached

2. **FINANCIAL NEED:** We use several methods to calculate financial need, there are no strict cut-offs and we look at the totality of evidence to help us make this determination. One method is the federal poverty standard. This includes proof of participation in a need-based government programs (i.e., Social Security Insurance, SNAP or Medicaid, but not SSDI). Please speak with us if you have questions regarding financial need.
   **Check to confirm document is attached

3. **MEDICAL NEED:** a letter from your primary healthcare provider that recommends the therapeutic use of cannabis as part of an approved treatment plan.
   **Check to confirm document is attached

4. **OTHER:** If you have documentation not included in items 1 or 2, you may submit along with an explanation of how the documentation deancial need.

I certify under penalty of perjury that the information is true and correct to the best of my knowledge and that the cannabis purchased with the Compassionate Care Discount is for my personal use**:

Signed:_____ Date:_____

***This program is not intended for recreational use or to be shared with friends. Once accepted into the program, if you are found to be purchasing for other people, you will be removed from the program and deemed ineligible for re-application. The Compassionate discount cannot be combined with any other discount, promotion or coupon. Any purchases made with the discount will not earn loyalty points, nor can points be redeemed in conjunction with the discount. Sespe Creek reserves the right to end the program at any time, adjust the discount amount, and/or restrict which products are available for compassionate discounts.*

Compassionate Care Program Application

Personal Statement
Briefly tell us anything else that you feel may be of significance when considering your application.