SAN MATEO COUNTY HEALTH
Medical Marijuana Identification Card Program

1600 W. Hillsdale Blvd #203 San Mateo, CA 94402 Telephone 650.573.2395 Fax 650.573.2576
http://www.smchealth.org

INSTRUCTIONS – PRIMARY CAREGIVER

Please read the following before submitting an application

Who may apply?
Participation in the Medical Marijuana Identification Card (MMIC) Program is voluntary. The MMIC expires within one year. The renewal process is the same as the initial application process and it is your responsibility to apply for a renewal. When submitting a primary caregiver's application, both the primary caregiver and the qualified patient must be present. If the patient is under the age of 18 years old, his/her parent must also be present.

You must apply in person with the following information at the Office of Vital Records located at 1600 W. Hillsdale Blvd #203, San Mateo, CA 94402.

Primary Caregiver Responsibilities
It is your responsibility to ensure you meet these criteria before continuing with the application process.

1. Complete the appropriate section of the Application Form DHS 9042.

2. Provide a government-issued photo identification card (i.e. California driver's license or California issued Identification Card).

3. If you as the primary caregiver have been designated as the primary caregiver by two or more qualified patients, you and all the qualified patients must reside in the same county.

4. Provide proof of your residency in the State of California.

5. Provide a written statement documenting how you, the primary caregiver, consistently assumes responsibility for housing, health, and/or safety of the patient.

6. Be prepared to pay the $100 fee required by the County of San Mateo's MMIC Program. If the patient is a Medi-Cal beneficiary, the caregiver is entitled a 50% reduction in fees making the fee required by the County of San Mateo's MMIC Program $50. Cash, credit card or check accepted. Application fees are non-refundable.

7. You must submit a complete and accurate application. Any omitted information or inaccurate information is grounds for a denial and you may be restricted from applying for the following six months. Application fees are non-refundable**.**

Medical Marijuana Program
APPLICATION/RENEWAL
(Please Print)

This application is for:

☐ Primary Caregiver Only

SECTION 1 TO BE COMPLETED BY ALL APPLICANTS.

Name (last, first, middle initial)

Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Additional contact information

Is applicant under 18 years of age? ☐ Yes ☐ No

If yes, complete Section 2 for the parent, legal guardian, or person with legal authority to make medical decisions for minor applicant, unless minor applicant is *(check one)*:

☐ Lawfully emancipated; *or* ☐ Declares self-sufficient minor status or is a minor capable of medical consent

SECTION 2 TO BE COMPLETED FOR MINOR APPLICANT IDENTIFIED IN SECTION 1.

Parent/guardian/other name (last, first, middle initial)		Telephone number if different from above ( )	
Mailing address if different from above (number, street)	City	State	ZIP code

Relation to applicant *(check one)*:

☐ Parent with legal authority to make medical decisions
☐ Legal Guardian
☐ Other person or entity with legal authority to make medical decisions

SECTION 3 TO BE COMPLETED IF THE APPLICANT IS UNABLE TO MAKE HIS/HER OWN MEDICAL DECISIONS.

Does the applicant have the capacity to make medical decisions? ☐ Yes ☐ No

If "No," enter the name and address of person acting on the applicant's behalf:

Name (last, first, middle initial)			Telephone number ( )
Mailing address (number, street)	City	State	ZIP code

Check one of the following to indicate the legal authority of the person (legal representative) signing this application on behalf of the applicant:

☐ I am the conservator for the applicant and I have authority to make medical decisions.
☐ I am an attorney-in-fact under a durable power of attorney for health care.
☐ I am a surrogate decision maker authorized under an advanced healthcare directive.
☐ I am authorized by statutory or decisional law to make medical decisions for the applicant, as follows:

☐ Parent ☐ Legal Guardian ☐ Other *(please specify)*: _____

SECTION 4 TO BE COMPLETED BY THE PRIMARY CAREGIVER REQUESTING AN IDENTIFICATION CARD.

Name (last, first, middle initial)			Date of birth (if less than 18 years of age)
Mailing address (number, street)			Telephone number ( )
City	State	ZIP code	County of residence

Primary Caregiver Duties: *(Document how you consistently assume responsibility for the housing, health, or safety of the applicant.)*

Check your designation as a primary caregiver from the following list:

☐ I am the parent of the applicant or the person entitled to make medical decisions on behalf of the applicant.
☐ I am the designated primary caregiver for only this applicant.
☐ I am the designated primary caregiver for another applicant (qualified patient) in this county.
☐ I am the designated primary caregiver for an applicant (qualified patient) in a different county.

County name: _____

Check one of the two following choices if your status as a primary caregiver is linked to a health related entity:

☐ I am the owner/operator of a clinic pursuant to Chapter 1 (commencing with Section 1200), Division 2 of the Health and Safety (H&S) Code.
☐ I am a clinic/facility/hospice or home health agency employee* designated by the owner/operator to serve as a primary caregiver.

Check all that apply:

☐ This health care facility is licensed pursuant to Chapter 2 (commencing with Section 1250), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.01 (commencing with Section 1568.01), Division 2 of the H&S Code.
☐ This residential care facility is licensed pursuant to Chapter 3.2 (commencing with Section 1569), Division 2 of the H&S Code.
☐ This hospice or home health agency is licensed pursuant to Chapter 8 (commencing with Section 1725), Division 2 of the H&S Code.

* Health and Safety Code, Section 11362.7(d)(1), limits a maximum of three employees that may serve as primary caregivers. **Note:** Include a copy of this page for each caregiver.

Primary Caregiver Declaration: I understand and acknowledge my assigned duties as the designated primary caregiver for

_____. I understand that if the applicant's identification card expires, then my primary caregiver
Applicant's name

identification card shall also expire. I agree to return my primary caregiver identification card to this county health department or its designee if this applicant changes primary caregivers. I agree that if I am the owner or operator of a health care facility designated as the primary caregiver of this applicant, that I shall notify this county health department or its designee if a change of primary caregivers is made. I declare under penalty of perjury that the information I provided on this form is true and correct.

_____
Printed name of primary caregiver

_____ _____
Signature of primary caregiver Date