Colorado Department of Public Health and Environment

Medical Marijuana Registry

4300 Cherry Creek Drive South, Denver, CO 80246-1530 • 303-692-2184
E-mail: medical.marijuana@state.co.us • **Website:** www.cdphe.state.co.us/hs/medicalmarijuana

FW

Request for Fee Waiver/Tax-Exempt Status

Instructions:

1. Complete all required sections of the form neatly and accurately.
2. **There are no fees to file this form.** DO NOT send money to the Registry. All monies received at the Registry are nonrefundable.
3. **Do not write-over, cross-out, or use white-out on this form, or it will be voided**. If you make a mistake on the form, please complete a new one.
4. After completing the form, you must sign and date it in front of a notary and have it notarized.
5. **Include a copy of your valid ID.** The chart below lists the documents the Registry will accept:

PROOF OF IDENTITY

The Registry requires a verifiable ID for all forms. Please submit one of the following IDs with your form:

- Colorado Driver's License
- Colorado ID
- Temporary Colorado Driver's License
- Temporary Colorado ID
- Out-of-state Driver's License
- Out-of-state ID
- U.S. Passport or passport card
- Military ID (copy of front and back)
- Tribal ID

If you do not have the above documents, please contact the Registry at 303-692-2184 (ext. 3) to discuss other options.

i. All documents must be currently valid when received at the Registry.
ii. Damaged, expired, or tampered IDs are not valid.
iii. Passports must include full photo page and signature page. Passport cards must include copy of front and back.
iv. The address on the ID **does not** have to match the mailing address on the form.
v. All IDs must be verifiable and have specific issue and expiration dates.
vi. The ID must show the patient's date of birth.

6. Patient social security numbers are used to confirm identity and protect confidentiality.
7. Tax-exempt status allows patients to apply for a Medical Marijuana Registry card without paying the application fee. It also allows patients to purchase medical marijuana without paying Colorado sales taxes. You may qualify for a fee waiver if your household income is 185% of the Federal Poverty Level or less. The chart below indicates the annual household incomes, adjusted for family size, that qualify.

Household incomes at 185% of 2013 Federal Poverty Guidelines*
Source: Federal Register, Vol. 78, No. 16, January 24, 2013, pp. 5182-5183.

# in Family	Annual Income
1	$ 21,257
2	$ 28,694
3	$ 36,130
4	$ 43,567
5	$ 51,005
6	$ 58,442
7	$ 65,879
8	$ 73,316
Each additional	$ 7,437

*Poverty guidelines are updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 U.S.C. 9902(2)

8. To prove household income, you must submit a certified copy of your most current State tax return. Tax returns must be within the last two years to qualify. You can request a **certified** copy of your Colorado tax return by completing form DR-5714 'Request for Copy of Tax Returns' available at www.colorado.gov/cms/forms/dor-tax/dr5714.pdf. The form must be completed, notarized and sent to the Colorado Department of Revenue for processing.

9. Incomplete Requests for Fee Waiver/Tax Exempt forms will be voided and returned to you. The form is considered complete when:
   a. The form is completed, signed and notarized.
   b. A copy of the patient's ID.
   c. A certified copy of your most current State tax return.
10. Make a copy of all your paperwork. Keep the copy for your files. Submit your originals to the Registry.
11. **To have the application fee waived,** this form must be submitted with your application packet.
12. **To request a change in tax-exempt status after you have your Registry card,** submit the complete form to the Registry within 10 days of the date it is notarized.
13. **The primary parent or legal guardian's signature is required on all forms for patients under the age of 18.**
14. **Authorized Representatives** –If patient care rights and responsibilities have been legally assigned to another person, a copy of the legal documentation must be on file with the Registry. Acceptable documents include court-certified guardianship documents, power of attorney or medical power of attorney. Medical care rights must be included as a responsibility of the guardian/agent in order to contact the Registry regarding patient records and care. A copy of the guardian/agent's ID is also required.
15. Please allow 4 to 6 weeks from the date the Registry receives your paperwork for processing. If you have not received a response within 6 weeks, please contact the Registry at 303-692-2184. Your paperwork or card will be mailed to the address on your paperwork. Cards are not valid outside of Colorado, thus the Registry does not mail cards outside of the State.
16. Submit paperwork by mail or deliver to the drop-box. **The Registry does not accept forms by fax or e-mail.**

Mail to:

Application Processing
CDPHE
HSV-8608
4300 Cherry Creek Drive South
Denver, CO 80246-1530

Drop-Box:
Colorado Dept. of Public Health & Environment
710 S. Ash Street, South East Entrance
Open: Monday-Friday, 7:00 a.m. to 6:00 p.m.
The drop box is on the wall inside the first set of glass doors. Your paperwork must be in a sealed envelope. You will not receive a receipt. **If you wish to have a receipt, please mail in your paperwork by certified mail.**

For more information, visit our website www.cdphe.state.co.us/hs/medicalmarijuana or call 303-692-2184.

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STAFF ONLY

_____ **Evaluated**

_____ **Replacement Card Printed**

Corrections:

Request for Fee Waiver/Tax-Exempt Status

This form is not valid as a temporary registry card.

See instructions on page 1. Proof of identification required with all forms.

Section A: Patient Information (Required)
The name on the form must match the legal name on your ID.

1. Social Security Number (optional) - -				
2. Last Name		3. First Name		4. Middle Initial
5. Mailing Address		5a. Apartment/Suite #		6. City
State **CO**	7. Zip Code	8. County	9. Date of Birth - -	10. Telephone Number ( ) -
11. E-mail Address (optional)*				

* By providing your e-mail address, you agree to receive communication from the Registry by e-mail.

12. ☐ I am enclosing a certified copy of the previous year's Colorado tax return as proof of income. (Required.)

13. Income criteria is based on household size. Please list all individuals included on your Colorado tax return.

List all the people in the household who were listed on your Colorado tax return.			
Last Name	**First Name**	**Date of Birth (mm/dd/yyyy)**	**Relationship to Patient**
1.		- -	
2.		- -	
3.		- -	
4.		- -	
5.		- -	
6.		- -	

☐ Please see additional family member names on back. There are _____ (# of people) additional names on the back.

I hereby certify that all information provided is correct and complete.

15. Patient's or Authorized Representative's Signature: ▶	16. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me in

_____ County, Colorado on this _____ day of _____, 20____.
(County name) (Day) (Month)

_____
(Notary's official signature)

_____
(Commission expiration date)

AFFIX NOTARY SEAL

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Patient's Name: _____ **Patient's Social Security Number:** ____-_____-_____

STAFF ONLY

_____
Evaluated

Corrections:

List all the people in the household who were listed on your Colorado tax return.

Last Name	First Name	Date of Birth (mm/dd/yyyy)	Relationship to Patient
7.		- -	
8.		- - -	
9.		- -	
10.		- -	
11.		- -	
12.		- -	
13.		- -	
14.		- -	
15.		- -	
16.		- -	
17.		- -	
18.		- -	
19.		- -	
20.		- -	