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

HB

Change of Homebound Status

Instructions:

1. Complete all required sections of the form neatly and accurately.
2. **There are no fees to file this form.**
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 Colorado ID.** The chart below lists the documents the Registry will accept:

PROOF OF IDENTITY	
The Registry requires a verifiable, photo ID for all forms. Please submit one of the following IDs with your form:	
• Colorado Driver's License • Colorado photo ID • Temporary Colorado Driver's License • Temporary Colorado ID	• Out-of-state Driver's License • Out-of-state photo ID • U.S. Passport • Military ID (copy of front and back) • Tribal ID
i. All documents must be currently valid when received at the Registry. ii. Damaged, expired, or tampered IDs are not valid. iii. The address on the photo ID **does not** have to match the mailing address on the form. iv. All IDs must be verifiable and have specific issue and expiration dates. v. The ID must show the patient's date of birth.	

6. You may **only** change your caregiver or Medical Marijuana Center one time per month. As a homebound patient, you will need to select a caregiver who will be responsible for transporting your medical marijuana.
7. Patient social security numbers are used to confirm identity and protect confidentiality.
8. Incomplete forms will be voided and returned to you. A form is considered complete when:
   a. The form is completed, signed and notarized.
   b. A copy of the patient's photo ID.
   c. A copy of the caregiver's ID must be included, if the form has caregiver information.
9. Forms must be sent separately, one form per envelope.
10. Make a copy of all your paperwork for your files.
11. Unless a fee is required, DO NOT send money to the Registry. All monies received at the Registry are nonrefundable.
12. Send in your form within 60 days of the physician's signature on the Physician Certification. Forms with Physician Certifications **more than 60 days old are rejected.**
13. **Please allow 4 to 6 weeks** from the date the Registry receives your form 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 form. Cards are not valid outside of Colorado, thus the Registry does not mail cards outside of the state.
14. Submit forms by mail or deliver to the Registry's drop-box. **The Registry does not accept forms by fax or e-mail.**

Mail To:

Status Change
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 www.cdphe.state.co.us/hs/medicalmarijuana, call 303-692-2184 or e-mail us at medical.marijuana@state.co.us.

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HB

STAFF ONLY

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Evaluated

Data Entry

a)

Card Printed

Corrections:

Change of Homebound Status

This form is not valid as a temporary registry card

See instructions on page 1. Photo ID required with all forms.

1. Social Security Number (optional)	**Section A: Patient (Required)** **The name on the form must match the legal name on your photo**			
2. Last Name	3. First Name			4. Middle Initial
5a. Mailing Address		5b. Apartment/Suite #		6. City
State **CO**	7. Zip Code	8. County	9. Date of Birth	10. Telephone Number
11. E-mail Address (optional)*				12. Gender ☐ Male ☐Female

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

13. Please check (✓) the statement below that describes the change you are requesting.
- ❑ Change my patient status to **Homebound**.
- ❑ Change my patient status to **Not Homebound**.

Section B: Caregiver Information (Required)				
A copy of the caregiver's photo ID is required. The name on the form must match the legal name on the caregiver's ID.				
14. Caregiver's Last Name (as on ID)	15. Caregiver's First Name (as on ID)			16. Middle Initial
17. Caregiver's Mailing Address			17a. Apartment/Suite #	
18. City	19. State	20. Zip Code	21. Date of Birth	22. Telephone Number

Section C: Medical Marijuana Center Information (Optional)			
Only homebound patients, or patients under age 18, may list both a caregiver and a Medical Marijuana Center.			
23. Name of Medical Marijuana Center			
24. Mailing Address of the Medical Marijuana Center			24a. Apartment/Suite #
25. City	State **CO**	26. Zip Code	27. Telephone Number

I hereby certify that the above information is correct and complete.

28. Patient's Signature: ▶	29. Date Signed: (mm/dd/yyyy)

The signature and proof of identity of the above individual was subscribed and sworn to before me by _____ in _____ County, Colorado
(Name of patient printed by notary) (County name)

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

_____
(Notary's official signature)

_____
(Commission expiration date) AFFIX NOTARY SEAL

Colorado Department of Public Health and Environment

Physician Certification Instructions

1. Complete the entire form, sign and date.
2. If you make a mistake on this form, please complete a new form. **Do not write over, white-out or cross-out information. This will void the form.**
3. Please keep a copy of the form in the patient's medical record. To avoid fraud, the Registry verifies all physician signatures. You will receive a verification letter for patients in the months the Registry receives Physician Certifications with your signature.
4. Auto defaults:
   - If Question #7 is incomplete, the auto-default response is "no."
   - If question #21 is incomplete, the auto-default responses is "standard amount."
5. **Please do not fax or e-mail the form to the Registry.** The patient must submit the Physician Certification along with his or her complete Medical Marijuana Registry application packet.
6. This does not constitute a prescription for marijuana.
7. To sign the form, you must be an MD or DO with an active Colorado medical license. Physicians with conditions or restrictions on their licenses, or out-of-state licenses, are not accepted.
8. A copy of your current DEA certification must be on file with the Registry. If you have not already provided this, please fax a copy to 303-758-5182. If your DEA is not on file when we receive your patient's paperwork, it will be rejected.
9. **The Registry cannot accept paperwork on security paper that reads "VOID" when copied.**
10. Encourage patients to submit their application packets as soon as possible after you sign the Physician Certification. **The Registry rejects Physician Certifications that are more than 60 days old.**
11. The Registry has included in the application packet, for your review, **"Regulation 8: Physician requirements; reasonable cause for referrals of physicians to the Colorado Medical Board; reasonable cause for department adverse action concerning physicians; appeal rights."** For a link to the complete Board of Health rules, please visit our website www.cdphe.state.co.us/hs/medicalmarijuana.
12. You may contact the Registry at medical.marijuana@state.co.us or (303) 692-2184, if you have any questions.

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PC

Physician Certification

See instructions on page 1. Photo ID required with all forms.

STAFF ONLY

_____
Evaluated

Corrections:

Patient Information

1. Last Name	2. First Name	3. Middle Initial	4. Date of Birth:

5. What is the date of physical examination for the purpose of the medical marijuana recommendation? (mm/dd/yyyy)

6. Are you available to provide follow-up care for this patient? ☐Yes ☐No

7. In your opinion, is this patient homebound? ☐ Yes ☐ No

Physician Information

8. License Number DR -	9. Last Name	10. First Name	11. Middle Initial

12. Mailing Address

13. City	14. State	15. Zip Code

16. Telephone Number	17. Fax Number	18. E-mail Address (optional)

19. DEA Certification: The Registry requires a copy of your current DEA certification for their files. If you have not already provided this, **FAX a copy to 303-758-5182 to prevent delays in processing this application.**

Physician's Statement

20. The above-named patient has been diagnosed with and is currently undergoing treatment for the following chronic, debilitating medical condition.

☐ a. Cancer ☐ b. Glaucoma ☐ c. HIV or AIDS positive

or The patient has a chronic or debilitating disease or medical condition that produces one or more of the following and which, in the physician's professional opinion, may be alleviated by the medical use of marijuana.

☐ d. Cachexia ☐ e. Severe nausea ☐ f. Seizures ☐ g. Persistent muscle spasms

☐ h. Severe pain (The etiology is required by law whenever severe pain is selected.)

Etiology: _____**or** ☐ Etiology unknown.

21. Please indicate the number of plants and ounces of marijuana you recommend for this patient.

☐ Standard Amount: 6 plants/2 ounces

☐ Increased Amount: _____ plants/_____ ounces

22. Comments: (If no comments, the Registry recommends crossing through this area to prevent comments after your signature.) _____

I hereby certify that I am a physician duly licensed in good standing to practice medicine in Colorado, and that I have a bona fide physician-patient relationship with the above-named patient. I have assessed this patient's medical history and current medical condition. I conclude that this patient may benefit from the medical use of marijuana. This assessment is not a prescription for the use of marijuana.

23. Physician's Signature:	24. Date Signed: (mm/dd/yyyy)
▶	