Facility Caregiver Designation Form

Overview

A registered medical marijuana patient may designate a facility as his or her designated caregiver. Pursuant to regulation, "facility" means: a general hospital or residential health care facility operating pursuant to Article 28 of the Public Health Law; an adult care facility operating pursuant to Title 2 of Article 7 of the Social Services Law; a community mental health residence established pursuant to section 41.44 of the Mental Hygiene Law; a hospital operating pursuant to section 7.17 of the Mental Hygiene Law; a mental hygiene facility operating pursuant to Article 31 of the Mental Hygiene Law; an inpatient or residential treatment program certified pursuant to Article 32 of the Mental Hygiene Law; a residential facility for the care and treatment of persons with developmental disabilities operating pursuant to Article 16 of the Mental Hygiene Law; a residential treatment facility for children and youth operating pursuant to Article 31 of the Mental Hygiene Law; or a private or public school. Once registered as a designated caregiver, the facility may assist the patient with the possession, acquisition, delivery, transfer, transportation, and/or administration of approved medical marijuana products.

Important Notes – Please Read

- The patient or the patient's proxy must complete all fields in Part I of this form and sign the form.
- An authorized facility representative must complete all fields in Part II of this form and sign the form.
- If needed, an authorized unit representative must complete all fields in Part III of this form and sign the form.
- The facility shall save a copy of this form.
- This form is only valid with a valid patient registry ID card. Please keep a photocopy of the patient's ID card with this form.
- Each designated caregiver facility, or facility unit, may service up to five (5) patients at any one time.
- A copy of this form should be maintained in the patient's medical record for five (5) years.

Application Submission Instructions

- Complete the application form DOH-5256.
- Submit the form via one of the following methods, **please do not do both**:
  - E-mail the completed form to **mmp@health.ny.gov**
  - Mail a paper copy to:

New York State Department of Health
Medical Marijuana Program
PO BOX 2071
Albany, NY 12220

When Department review has been completed, you will receive a processed copy of this form, which will serve as the facility caregiver registry identification card.

I. To Be Completed by Registered Patient or the Patient's Proxy

Patient Name _____ _____
FIRST NAME LAST NAME

Date of Birth _____ Facility Name _____
MM/DD/YYYY

Medical Marijuana Registry ID Card # (Located on the back of the ID Card, below the top barcode) _____

Certification Expiration Date: _____

As the patient named above, I attest to the following:

- *I am a certified patient and I am registered with the New York State Medical Marijuana Program.*
- *I understand that I may only designate up to two (2) caregivers, one of which is the facility mentioned above.*
- *I will promptly notify the Medical Marijuana Program once I no longer need to utilize this facility as a caregiver.*
- *I will promptly register and designate applicable caregivers if issued a new certification by my registered practitioner when my current certification expires.*
- *All the information provided is true and I acknowledge that a false statement is punishable under section 210.45 of the Penal Law.*

Signature of Patient or Proxy _____ **Date** _____

II. To Be Completed by the Facility

Facility Name _____

Facility Address _____

Authorized Facility Representative and Title _____

Operating Certificate or License # (if applicable) _____

Email _____ Phone _____

As an authorized representative of the above facility, I attest to the following:

- *The abovementioned facility agrees to secure and ensure proper handling of approved medical marijuana products.*
- *I understand that as a designated caregiver facility, authorized staff members may assist the abovementioned patient with possession, acquisition, delivery, transfer, transportation, storage and/or administration of approved medical marijuana products.*
- *The abovementioned facility agrees to promptly notify the Medical Marijuana Program if it wishes to no longer be a caregiver or the patient no longer resides in the facility.*
- *All the information provided is true and I acknowledge that a false statement is punishable under section 210.45 of the Penal Law.*

Signature of Authorized Facility Representative _____ **Date** _____

PLEASE NOTE

The Compassionate Care Act allows designated caregivers to service up to FIVE (5) medical marijuana patients at one time. In the event your facility needs to provide caregiver services to more than five (5) medical marijuana patients at one time, please complete the section below to further subdivide your facility into Divisions/Departments/Components/Floors or Units as appropriate. In doing so, each Division/ Department/Component/Floor or Unit may serve five (5) medical marijuana patients, thereby meeting the needs of the facility's patients.

III. To Be Completed by the Facility Division/Department/Component/Floor or Unit (Unit) if needed – Please see note above.

Facility Division/Department/Component/Floor/Unit _____

Authorized Facility Representative and Title _____

Email _____ Phone _____

As an authorized representative of the above unit, I attest to the following:

- *The abovementioned unit agrees to secure and ensure proper handling of approved medical marijuana products.*
- *I understand that as a designated caregiver facility, authorized staff members may assist the abovementioned patient with possession, acquisition, delivery, transfer, transportation, storage and/or administration of approved medical marijuana products.*
- *All the information provided is true and I acknowledge that a false statement is punishable under section 210.45 of the Penal Law.*

Signature of Authorized Unit Representative _____ **Date** _____

For NYS Department of Health Use Only	Registration ID #	Processed by
	Expiration Date	Date Processed

Questions? Contact the Medical Marijuana Program at 1-866-811-7957 or mmp@health.ny.gov