



### Compassionate Care Program Application

Full Name:	
Address:	
Phone:	Email:
HI 329 Card Registration Number:	Med-QUEST ID Number:
<b>Qualifying Condition:</b>	<b>Estimated Usage Under Current Treatment Plan:</b>

**Additional Documents Required:**

- ✓ Valid State Identification Card
- ✓ Valid Hawaii Medical Marijuana Card
- ✓ Valid Med-QUEST Card
- ✓ Med-QUEST Renewable Letter (received and dated within last 12 months)

**ALL** documents must have the same address.

**Terms and conditions:**

- Award may only be used at Noa Botanicals' dispensaries.
- Awards may be applied towards the purchase of medical cannabis only.
- Regardless of total award, no more than **USD \$50.00 (fifty dollars)** may be applied towards the purchase of medical cannabis each calendar month.
- Award amounts do not roll over each month. For example, if a patient is awarded \$600.00 for a calendar year, and only uses \$40.00 for the month of January, the remaining \$10.00 does not roll over. The remainder of the award is \$550.00 for the remainder of the year beginning February 1.
- Award amount applied may not exceed 50% of the medical cannabis purchase. For example, if your total purchase is \$60.00, you may only use \$30.00 of your award (for a 50% discount off the purchase).
- Awards are only available to current Med-QUEST recipients.
- Awards can only be used on regular priced items.
- If you lose your Med-QUEST status or eligibility, you must notify Noa Botanicals immediately.
- Awards may be revoked at any time at the discretion of Noa Botanicals.

I, the undersigned, declare that all the information provided is true to the best of my knowledge and that I am currently an active Med-QUEST recipient and financially eligible for the Med-QUEST program. I also declare that I have read the above information and had the opportunity to ask questions about the Compassionate Care program and agree to abide by the above Terms and Conditions for the duration of my award should I be granted an award by Noa Botanicals.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

**Internal Use Only**

Received / Completed	Documents Reviewed	Outcome
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