



Medical Cannabis Transportation Subsidy Program
Reimbursement Request

(Maximum reimbursable amount is \$25 per calendar month)

PLEASE COMPLETE TOP SECTION

Name of Individual Requesting Reimbursement: _____
Caregiver: ___ Yes ___ No

Rancho Mirage Address: _____

E-mail address: _____

Telephone Number: _____

Mailing Address for reimbursement: _____

City: _____ State: _____ Zip Code: _____

Please initial the following:

___ I am a resident of the City of Rancho Mirage or I am the caregiver of a resident of the City of Rancho Mirage.

___ The cooperative or collective does not provide delivery services.

Resident's/Caregiver Signature: _____ Date: _____

Name of cooperative/collective: _____

Address: _____

Telephone Number: _____

FOR OFFICE USE ONLY

PROOF OF ELIGIBILITY:

Any valid identification (i.e. driver's license or state-issued ID card), ***plus*** the following:

- ___ Utility bill with address shown as Rancho Mirage, Property Tax Bill with address shown as Rancho Mirage, or Rental agreement or lease (with a utility bill showing Rancho Mirage address).*
 - ___ Valid Medical Cannabis card.
 - ___ Bus ticket, or shuttle or taxi fare receipt validated by the dispensary, or receipt of purchase if private vehicle was used.
 - ___ For caregivers, proof of Primary Caregiver Status for patient.
- *Residency will be validated on a yearly basis.**

Date Reimbursement Request Received: _____ Reimbursed Amount Requested: _____

Authorized signature to approve reimbursement: _____

Authorized Official for the City of Rancho Mirage