



**California Phones**  
Keeping you connected.



**California Telephone Access Program**

California Public Utilities Commission Deaf and Disabled Telecommunications Program

# Apply Today! 3 Easy Steps:

## 1. Complete this section.

\_\_\_\_\_  
Last Name First Name MI

\_\_\_\_\_  
Street Address City State CA Zip

Your Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

Email Address \_\_\_\_\_ Year of Birth (optional) \_\_\_\_\_

Local Phone Company's Name \_\_\_\_\_

Name on Phone Bill (First & Last) \_\_\_\_\_

Ethnicity (optional):  Caucasian  Latino  African American  
 Native American  Pacific Islander  Asian  Other

I prefer materials in:  English  Spanish  Chinese  Vietnamese  
 Russian  Hmong  Braille  Large Print (English)  
 Large Print (Spanish)

How did you learn about us?  Radio  Television  Newspaper  Event  
 Bus Ad  Online  Other \_\_\_\_\_

Alternate Contact (First & Last) \_\_\_\_\_

Relationship \_\_\_\_\_

Phone Number ( \_\_\_\_\_ ) \_\_\_\_\_

**IMPORTANT, READ BEFORE SIGNING** Limited Liability Agreement The applicant hereby agrees that the CPUC and/or the State of California, and/or the California Communications Access Foundation (CCAF) make(s) no warranties, either express or implied, with regard to the possession, use, condition, and/or operation of the telecommunications equipment provided to applicant as part of this program (the Equipment). The applicant hereby agrees to indemnify, defend, and hold harmless the CPUC, the State of California, and/or the CCAF from any and all third party claims, costs (including without limitation reasonable attorneys' fees), and losses which in any way arise out of or in connection with the possession, use, condition, and/or operation of the Equipment. The applicant hereby agrees that the CPUC, the State of California, and/or the CCAF shall have no liability to the applicant or any other person with respect to any liability, loss, or damage caused or alleged to be caused, directly or indirectly, by or through the possession, use, and/or operation of the Equipment. I verify that I live in a household that subscribes to local telephone service in California.

**NOTE:** Please choose your equipment carefully because we want to provide you the most appropriate phone. CTAP will repair or exchange equipment if 1) the equipment loaned to the consumer stops working or malfunctions or 2) the consumer's disability certification changes. Please return your equipment with all original parts in the manufacturer's packaging.

Signature of Applicant

Date

## 2. Have this section completed by an authorized certifying agent.

- Licensed Medical Doctor
- Licensed Optometrist
- Licensed Audiologist
- Department of Rehabilitation Counselor
- Superintendent/Audiologist from the California School for the Deaf Fremont/Riverside
- Licensed Hearing Aid Dispenser (see provision below)\*
- Licensed Physician Assistant
- Licensed Speech-Language Pathologist

**Impairment(s) of the Applicant (Check All That Apply):**

- Deaf/Deafened    Mobility/Manipulation    Hard of Hearing    Blind    Low Vision    Speech    Cognitive  
**Hearing Loss:**    Mild    Moderate    Severe      **Mobility:**    Upper body    Lower Body    Both

Notes: \_\_\_\_\_

Signatory please write patient's name from page 1 here: \_\_\_\_\_

Address of patient from page 1: \_\_\_\_\_

*I certify that the above named person has the impairment(s) marked above that restrict(s) his or her use of the telephone and qualifies for equipment provided under California state legislation.*

Print Name (Must be legible) \_\_\_\_\_

Professional Credentials \_\_\_\_\_ License Number \_\_\_\_\_

Telephone (\_\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_

Signature of Certifying Agent \_\_\_\_\_ Date \_\_\_\_\_

(No stamped signatures accepted)

\*For Licensed Hearing Aid Dispensers - *I certify that I have fitted the above person with an amplified device and have the individual's hearing records on file.*

\_\_\_\_\_  
Signature (Hearing Aid Dispensers only)   Date   HAD License Number   Telephone

## 3. Choose one way to return this form.

► **Bring in your completed form to one of our Service Centers and get the phone the same day:**

- **Berkeley** Inside the Ed Roberts Campus, 3075 Adeline Street, Suite 260, CA 94703
- **Fresno** 7525 N. Cedar Avenue, Suite 115, CA 93720
- **Glendale** 425 West Broadway, Suite 105, CA 91204
- **Redding** 2861 Churn Creek Road, Suite A, CA 96002 *Limited Hours*
- **Riverside** 2002 Iowa Avenue, Suite 106, CA 92507
- **Sacramento** 1300 Ethan Way, Suite 105, CA 95825
- **Salinas** Inside the DHHSC Office, 339 Pajaro Street, Suite B, CA 93901 *Limited Hours*
- **San Diego** 1455 Frazee Road, Suite 406, CA 92108
- **Santa Ana** 2677 N. Main Street, Suite 130, CA 92705
- **Santa Barbara** Inside the Independent Living Center, 423 W. Victoria Street, CA 93101 *Limited Hours*

Please confirm addresses and hours of operation online or call.

► **Mail to: CTAP, P.O. Box 30310, Stockton, CA 95213**

► **Fax to: 1-800-889-3974**

**If you mail or fax your form, look for an approval letter in the mail within a week, and then call (or visit a Service Center) to determine the right phone for you!**



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For further information or more applications visit **www.CaliforniaPhones.org** Web chat available.

Contact Center hours: Mon-Fri (7am-6pm), Sat (9am-4pm)

English: 1-800-806-1191

國語: 1-866-324-8747

Tiếng Việt: 1-855-247-0106

Español: 1-800-949-5650

粵語: 1-866-324-8754

Русский: 1-855-546-7500

TTY: 1-800-806-4474

Hmoob: 1-866-880-3394

English email: [info@CaliforniaPhones.org](mailto:info@CaliforniaPhones.org)

Email en español: [info-es@CaliforniaPhones.org](mailto:info-es@CaliforniaPhones.org)

Office Use Only	Processed by
	Date

CRT-ENG-WEB-12F-DDTP