



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)

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.

**PRIVACY NOTICE:** The CPUC DDTP, under the authority of Public Utilities Code § 2881, uses this form to collect personal information solely for the purposes of identification and document processing. Unless otherwise noted, all requested information is mandatory, and incomplete information may result in incorrect processing. The information submitted will be held in confidence to the extent allowed by law and is available for your review, upon request. The DDTP complies with the Information Practices Act of 1977, and its Privacy Policy and contact information are online at <http://ddtp.cpuc.ca.gov/privacy.aspx>.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

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

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

**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

**Office Use Only**

Processed by	Date

CRT-ENG-WEB-15D

## 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:**  
See Service Center locations on this Web Site ([www.californiaphones.org](http://www.californiaphones.org))

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

► **Fax to: 1-800-889-3974**

If you mail, email 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! Then we can ship you your phone or you can pick it up at a Service Center.

For help completing this application, further information, or more applications, visit **[www.californiaphones.org](http://www.californiaphones.org)** Web Chat available.

Contact Center hours: Mon-Fri (7 AM-6 PM), Sat (9 AM-4 PM), except holidays. Eng-

- English: 1-800-806-1191      Tiếng Việt: 1-855-247-0106
- Español: 1-800-949-5650      Русский: 1-855-546-7500
- 國語: 1-866-324-8747      Hmoob: 1-866-880-3394
- 粵語: 1-866-324-8754      TTY: 1-800-806-4474

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

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