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)

31608AA00005

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 ☐ 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

**Office Use Only**

| Processed by | Date |
|---|---|
| | |

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## 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)

▶ **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** Web Chat available.

Contact Center hours: Mon–Fri (7am–6pm), Sat (9am–4pm), except holidays.

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

**English email:** info@CaliforniaPhones.org

**Email en español:** info-es@CaliforniaPhones.org

California Phones
讓您隨時保持聯繫。