

CTSA Application Please Print

Date _____ Male / Female

Last Name: _____

First Name: Mr. / Mrs. / Ms. _____

Address _____

Phone _____ Zip _____

Birthdate _____

Emergency Contact #1 _____

Phone _____ Relationship _____

Emergency Contact #2 _____

Phone _____ Relationship _____

Can participant be left alone? ___ Yes ___ No

Mobility Aids Used: ___ Manual Wheelchair

___ Electric Wheelchair ___ Powered Scooter

___ Service Animal ___ Cane ___ Walker

Wheelchair Applicant Approximate Weight

80-139lbs 140-199lbs 200-260lbs

Visual Impairment: ___ Moderate

___ Severe ___ Completely Impaired

Hearing Impaired? ___ Yes ___ No

Alzheimer Day Care Center? ___ Yes ___ No

Does Client Require a Careprovider? ___ Yes ___ No

Dialysis Patient? ___ Yes ___ No

If under 60 years of age please have your Doctor complete the enclosed form.



SS-820

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Date _____ Male / Female

Last Name: _____

First Name: Mr. / Mrs. / Ms. _____

Address _____

Phone _____ Zip _____

Birthdate _____

Emergency Contact #1 _____

Phone _____ Relationship _____

Emergency Contact #2 _____

Phone _____ Relationship _____

Can participant be left alone? ___ Yes ___ No

Mobility Aids Used: ___ Manual Wheelchair

___ Electric Wheelchair ___ Powered Scooter

___ Service Animal ___ Cane ___ Walker

Wheelchair Applicant Approximate Weight

80-139lbs 140-199lbs 200-260lbs

Visual Impairment: ___ Moderate

___ Severe ___ Completely Impaired

Hearing Impaired? ___ Yes ___ No

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If under 60 years of age please have your Doctor complete the enclosed form.



SS-820

Please send completed application to:

**CTSA Office
222 Minner Ave.
Bakersfield, CA 93308**

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Bakersfield, CA 93308**

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*Be sure to enclose a note signed by your
doctor or agency representative confirming
your disability if under age 60.*

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