CTSA Application

Please Print

Date _____ Male / Female

Last Name: _____

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

Address _____

Phone _____ Zip _____

Birthdate _____

Medi-Cal # _____

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

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.

North of the River
recreation and park district

SS-820

CTSA Application

Please Print

Date _____ Male / Female

Last Name: _____

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

Address _____

Phone _____ Zip _____

Birthdate _____

Medi-Cal # _____

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

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.

North of the River
recreation and park district

SS-820

CTSA Application

Please Print

Date _____ Male / Female

Last Name: _____

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

Address _____

Phone _____ Zip _____

Birthdate _____

Medi-Cal # _____

Emergency Contact #1 _____

Phone _____ Relationship _____

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___ Electric Wheelchair ___ Powered Scooter

___ Service Animal ___ Cane ___ Walker

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.

North of the River
recreation and park district

SS-820

Please send completed application to:

CTSA Office
222 Minner Ave.
Bakersfield, CA 93308

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

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222 Minner Ave.
Bakersfield, CA 93308

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