



A Sempra Energy utility®

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY

Southern California Gas Company (SoCalGas®)'s California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households. To see if you qualify, check the requirements shown below. Please complete the application and return it by mail or fax. Once your completed and signed application is approved by SoCalGas, you will receive the CARE discount from your property owner/manager. You and your property owner/manager will be notified whether or not you are approved for the discount.

Or apply online at socialgas.com (Search "CARE")

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or someone in your household participates in any of these programs:
Medicaid or Medi-Cal
Medi-Cal for Families A&B
Women, Infants, & Children (WIC)
CalWORKs (TANF) or Tribal TANF
Head Start Income Eligible - Tribal Only
Bureau of Indian Affairs General Assistance
CalFresh (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective June 1, 2014 to May 31, 2015)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1-2	\$31,460
3	\$39,580
4	\$47,700
5	\$55,820
6	\$63,940
7	\$72,060
8	\$80,180
Each additional person	+\$8,120

CONDITIONS FOR PARTICIPATION

This address must be your primary address. / You must not be claimed as a dependent on another person's income tax return other than your spouse. / You must recertify your application when requested. / You must notify SoCalGas within 30 days if you no longer qualify. / You may be asked to verify your eligibility for CARE.

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

Energy Savings Assistance Program: Offers no-cost energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repairs to eligible low-income home-owners and renters. For more information, please call 1-800-331-7593.



Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

LIHEAP: Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Dept. of Community Services and Development at 1-866-675-6623.

California Lifeline: A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

FOR INFORMATION ON CUSTOMER ASSISTANCE, CALL:

English: 1-800-427-2200 Mandarin: 1-800-427-1429 Spanish: 1-800-342-4545
 Korean: 1-800-427-0471 Cantonese: 1-800-427-1420 Vietnamese: 1-800-427-0478
 Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)
 Fax: (213) 244-4665



CARE 20% Rate Discount Application

Form 6677-E EN (06/14)

Please use DARK ink and print clearly to ensure proper processing

CARE PROGRAM, ML GT19A1

PO BOX 3249

LOS ANGELES, CA 90051-1249

Correct way to mark circles: ●



1	Tenant Name (as it appears on your bill):	
	Home Address (street, space #, city, zip):	
	Facility ID:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Phone Number:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	E-mail Address:	<input type="text"/>

2	Total # of adults and children in your household:	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> If more than 6: <input type="text"/>
	<u>Are you (or someone in your household) enrolled in any of the following assistance programs?</u>	
	<input type="radio"/> YES (If yes, mark the program(s) of participation) ▼	
	<input type="radio"/> Medi-Cal / Medicaid: Under Age 65 <input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)	
	<input type="radio"/> Medi-Cal / Medicaid: 65 or older <input type="radio"/> Supplemental Security Income (SSI)	
	<input type="radio"/> Medi-Cal for Families A & B <input type="radio"/> National School Lunch Program (NSLP)	
	<input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Bureau of Indian Affairs General Assistance	
	<input type="radio"/> CalWORKs (TANF) or Tribal TANF <input type="radio"/> Head Start Income Eligible - Tribal Only	
	<input type="radio"/> CalFresh (Food Stamps)	
	<input type="radio"/> NO	
	What is your yearly household income (before deductions, including all members of the household)? ▼	
	<input type="radio"/> \$0 - \$31,460 <input type="radio"/> \$31,461 - \$39,580 <input type="radio"/> \$39,581 - \$47,700 <input type="radio"/> \$47,701 - \$55,820 <input type="radio"/> \$55,821 - \$63,940	
	<input type="radio"/> If more than \$63,940, enter amount here: \$ <input type="text"/> , <input type="text"/> .00 per year	
	Please mark your sources of income: ▼	
	<input type="radio"/> Social Security <input type="radio"/> Wages and/or Profit from Self Employment <input type="radio"/> Spousal or Child Support	
	<input type="radio"/> SSP or SSDI <input type="radio"/> Unemployment Benefits <input type="radio"/> Scholarships, grants, or other aid used for living expenses	
	<input type="radio"/> Pensions <input type="radio"/> Insurance or Legal Settlements <input type="radio"/> Rental or Royalty Income	
	<input type="radio"/> Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts <input type="radio"/> Disability or Workers Compensation Payments <input type="radio"/> Cash or Other Income	

3	Do you agree to the following? Please read and sign below. I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform SoCalGas if I no longer qualify to receive the discount. I understand that if I receive the discount without qualifying for it, I may be required to pay back the discount I received. I understand that SoCalGas can share my information with other utilities or agents to enroll me in their assistance programs.
	Signature: <input type="text"/> X Date: <input type="text"/> / <input type="text"/> / <input type="text"/>