

The California Alternate Rates for Energy (CARE) program offers eligible SoCalGas® customers a 20% discount on their monthly bill. The discount will be applied to the monthly bills following the date that the application is approved by SoCalGas.

Please submit a completed application by using one of the methods listed **below**:

- 1) Visit **myaccount.socalgas.com** or **socalgas.com/CARE**. Your request will be processed promptly.
- 2) Call 1-866-716-3452 anytime, 24 hours a day. Please have your account number ready.
- 3) Return the completed and signed form by mail or fax to (213) 244-4665.



THERE ARE **TWO** WAYS TO QUALIFY

PUBLIC ASSISTANCE PROGRAMS

If you or another person in your household receives benefits from any of the following programs:

- Medi-Cal / Medicaid
 - Medi-Cal for Families A&B
 - Women, Infants & Children (WIC)
 - CalWORKs (TANF)¹ or Tribal TANF
 - Head Start Income Eligible
 - Bureau of Indian Affairs General Assistance
 - CalFresh (food stamps)
 - National School Lunch Program (NSLP)
 - Low Income Home Energy Assistance Program
 - Supplemental Security Income
- ¹Includes Welfare-To-Work*

OR

MAXIMUM HOUSEHOLD INCOME

(effective June 1, 2024 to May 31, 2025)



Number of
Persons in
Household

1-2	\$40,880
3	\$51,640
4	\$62,400
5	\$73,160
6	\$83,920
7	\$94,680
8	\$105,440



Total
Annual
Income*

For each additional household member, add \$10,760

**Includes current household income from all sources before deductions.*

CONDITIONS FOR PARTICIPATION:

- 1)** You must meet the qualification requirements in one of the tables on page 2.
- 2)** The natural gas bill must be in your name and the address must be your primary address.
- 3)** You must not be claimed as a dependent on another person's income tax return other than your spouse.
- 4)** You must recertify your application when requested.
- 5)** You must notify SoCalGas within 30 days if you no longer qualify.
- 6)** You may be asked to verify your eligibility for CARE.

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:



Help for your home

Energy-saving home improvements from authorized local contractors at no cost

Energy Savings Assistance Program

socalgas.com/Improvements
1-800-331-7593



Help for medical needs

Additional natural gas at the lowest baseline rate for qualifying medical conditions

Medical Baseline

socalgas.com/Medical
1-866-431-3517



Help with your phone

Discounted telephone services for eligible customers

California Lifeline

Learn more at
californialifeline.com



Help with your bill

Utility bill assistance and weatherization services

Past due bill forgiveness available for eligible residential CARE customers

Low Income Home Energy Assistance

1-866-675-6623

Arrearage Management Plan

socalgas.com/Forgiveness
1-800-427-2200

FOR MORE INFORMATION ON CUSTOMER ASSISTANCE:

English: 1-800-427-2200

Español: 1-800-342-4545

FAX: 213-244-4665

Hearing Impaired (TDD/TTY): 1-800-252-0259

(available in English and Spanish only)

한국어: 1-800-427-0471

廣東話: 1-800-427-1420

Việt: 1-800-427-0478

中文: 1-800-427-1429

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These programs are funded by California utility customers and administered by Southern California Gas Company under the auspices of the California Public Utilities Commission. Program funds will be allocated on a first-come, first-served basis until such funds are no longer available. These programs may be modified or terminated without prior notice.

SOURCE CODE: 9Q EN LF

14237C-2024

PLEASE USE DARK BLUE OR BLACK INK ONLY

Please complete and return the application by mail, fax, or apply online at socalgas.com/CARE.

Mail to: SoCalGas CARE Program, P.O. Box 3249, Los Angeles, CA 90051-1249 or Fax to: (213) 244-4665

ACCOUNT NUMBER

(Please provide the first 10 digits of your account number)

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CUSTOMER NAME (AND LAST AS IT APPEARS ON YOUR BILL)

ADDRESS

APT/SPACE

CITY

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

PRIMARY PHONE

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1

Total number of persons in your household
(include yourself, other adults, and children):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

☐ If more than 6:

2

Are you (or someone in your household) enrolled in any of the following assistance programs?

- ☐ **YES** (If yes, please fill in the circle(s) ●)
- ☐ Medi-Cal/Medicaid: Under age 65
- ☐ Medi-Cal/Medicaid: 65 or older
- ☐ Medi-Cal for Families A&B
- ☐ Women, Infants, and Children Program (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 (LIHEAP)
- ☐ Supplemental Security Income

- ☐ **NO** (If no, what is your yearly household income before deductions, including all members of the household?)

- ☐ \$0 - \$40,880
- ☐ \$40,881 - \$51,640
- ☐ \$51,641 - \$62,400
- ☐ \$62,401 - \$73,160
- ☐ \$73,161 - \$83,920

- ☐ If more than \$83,920, enter the dollar amount here

\$, 00 per year.

2

(continued)

Please mark your sources of income:

- ☐ Social Security
- ☐ SSP or SSDI
- ☐ Pensions
- ☐ Interest or dividends from savings, stocks, bonds, or retirement accounts
- ☐ Wages and/or salary
- ☐ Unemployment benefits
- ☐ Insurance or legal settlements
- ☐ Disability or workers compensation payments
- ☐ Spousal or child support
- ☐ Scholarships, grants, or other aid used for living expenses
- ☐ Rental or royalty income
- ☐ Cash, other income, or profit from self-employment

3**Declaration, 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 program eligibility if asked. I agree to inform SoCalGas within 30 days if I no longer qualify to receive a discount. I understand that if I receive the discount without qualifying for it, I am required to pay back the discount I received. I authorize SoCalGas to share my information in order to remain eligible for available energy management assistance, and price reduction and residential rate programs with other utilities, state agencies and entities designated by the CPUC.

SIGNATURE:

DATE: / /