20% DISCOUNT
CARE APPLICATION

The California Alternate Rates for Energy (CARE) program offers eligible SoCalGas® customers a 20% discount on their monthly natural gas bill. The discount will be applied to the monthly bill following the date that the application is approved by SoCalGas. If you are a submetered tenant, your property owner/manager will be notified whether or not you are approved to receive the discount.

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

1) Visit **socalgas.com/CARE** and apply as a submetered tenant.

2) Call 1-866-716-3452 anytime, 24 hours a day. Please have your Facility ID 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] / 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

[1]Includes Welfare-to-Work

OR

MAXIMUM HOUSEHOLD INCOME
(effective June 1, 2021 to May 31, 2022)

Number of Persons in Household	Total Annual Income*
1-2	$34,840
3	$43,920
4	$53,000
5	$62,080
6	$71,160
7	$80,240
8	$89,320

For each additional household member, add $9,080

*Includes current household income from all sources before deductions.

CONDITIONS FOR PARTICIPATION:

1) You must meet the qualification requirements in the table on page 2.
2) 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

Receive energy-saving home improvements at no cost that can help you save money and make you more comfortable

Energy Savings Assistance Program™
socalgas.com/improvements
1-800-331-7593

HELP FOR MEDICAL NEEDS

Get additional natural gas at the lowest baseline rate if you have a serious health condition

MEDICAL BASELINE
socalgas.com/medical
1-866-431-3517

HELP WITH YOUR PHONE

Discounted telephone services for eligible customers

CALIFORNIA LIFELINE
For more information contact your telephone service provider

HELP WITH YOUR BILL

Bill payment assistance, emergency bill assistance and weatherization services

LOW INCOME HOME ENERGY ASSISTANCE
1-866-675-6623

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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The CARE program is 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. This program may be modified or terminated without prior notice. SOURCE CODE: 9Q LARGE FONT N21E043A 0421

CARE APPLICATION 20% DISCOUNT

PLEASE USE DARK BLUE OR BLACK INK ONLY

Please complete and return the application by mail or fax.

Mail to: SoCalGas M.L. GT19A1, P.O. Box 3249 Los Angeles, CA 90051-1249 or Fax to: (213) 244-4665

PLEASE PROVIDE YOUR MASTER ACCOUNT AND FACILITY ID TO EXPEDITE THE PROCESS.

MASTER ACCOUNT NUMBER

FACILITY ID

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

ADDRESS

SPACE #

CITY

PRIMARY PHONE

- -

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 - $34,840
- ○ $34,841 - $43,920
- ○ $43,921 - $53,000
- ○ $53,001 - $62,080
- ○ $62,081 - $71,160
- ○ If more than $71,160, 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 eligibility if asked. I agree to inform Southern California Gas Company (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 understand that SoCalGas can share my information with other utilities or agents to enroll me in their assistance programs.

SIGNATURE: X ______________________

DATE: __ __ / __ __ / __ __

Source Code: 9Q
Form 6677 EN Lrg Font
Meter: Submetered