



20% DISCOUNT CARE APPLICATION

FOR QUALIFIED NONPROFIT GROUP LIVING FACILITIES

CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM

The CARE program provides a 20% monthly discount on the natural gas bill of nonprofit group living facilities that meet the program criteria established by the California Public Utilities Commission (CPUC). The discounted rate is available to qualified facilities once SoCalGas® receives and approves the application.

INSTRUCTIONS:

- 1 READ** the information on pages 2 and 3. If you have questions, call SoCalGas at 1-800-427-2200.
- 2 DETERMINE** if the facility meets the definition of a “qualified nonprofit group living facility.” The facility **MUST** meet **ALL** criteria to qualify for the 20% monthly discount.
- 3 COMPLETE** and **SUBMIT** the entire application (please print). Complete a separate application for each qualified facility (including satellite facilities).
- 4 ATTACH** all required documents. Application will not be approved without all requested documentation.
- 5 MAIL TO:** SoCalGas
CARE PROGRAM GT19A1
PO BOX 513249
LOS ANGELES, CA 90051





ELIGIBLE FACILITIES

Nonprofit Group Living Facilities:

If you are operating a women’s shelter, homeless shelter, hospice or a nonprofit group living facility, your facility may be eligible to save on its monthly natural gas bill. Eligible group living facilities may include transitional housing (drug rehabilitation facilities, half-way houses), short-term or long-term care facilities (hospice, nursing homes, senior’s or children’s homes) or group homes for physically or mentally disabled persons.

Facility Requirements

- Have tax-exempt status under Internal Revenue Code Section 501(c)(3).
- Use at least 70 percent of the facility’s natural gas consumption for residential purposes.
- Re-certify eligibility upon request to remain enrolled in the program.
- Use the CARE discount for the direct benefit of the facility’s residents.
- Ensure that all of the facility’s residents meet the CARE eligibility guidelines (as shown in the chart on page 3).

Satellite Facilities:

- A nonprofit group living facility may consist of a licensed primary facility and related non-licensed facilities at other locations (satellites).
- The primary facility must be licensed by the appropriate state agency or provide adequate proof of eligibility and meet all other CARE criteria.
- At least 70 percent of the natural gas used at the satellite facility must be for residential purposes.
- The primary licensed facility’s name must appear as the customer-of-record on the natural gas bill for the satellite facility.

FACILITIES NOT ELIGIBLE

- Group living facilities offering only a place to live and no other services.
- Nonprofit facilities providing social services only.
- Student housing/dorms, military barracks, fraternities/sororities, privately owned for-profit housing, and government-subsidized housing.
- Government-owned and/or government-operated facilities.



HOW TO QUALIFY/RECERTIFY

For the CARE program

Approved facilities are required to recertify for the CARE program upon request. An application will be mailed when it is time to recertify. Facilities must include total savings from the prior year and information on how the discount was used for the direct benefit of the qualified residents.

THERE ARE TWO WAYS TO QUALIFY

| PUBLIC ASSISTANCE PROGRAMS | ←OR→ | MAXIMUM HOUSEHOLD INCOME (Effective June 1, 2021 to May 31, 2022) | |
|---|------|---|----------------------|
| The individual resident in the facility receives benefits from any of the following programs: | | Number of Persons in Household | Total Annual Income* |
| Medi-Cal/Medicaid | | 1-2 | \$34,840 |
| Medi-Cal for Families A & B | | 3 | \$43,920 |
| Women, Infants, & Children (WIC) | | 4 | \$53,000 |
| CalWORKs (TANF) ¹ / Tribal TANF | | 5 | \$62,080 |
| Head Start Income Eligible – Tribal Only | | 6 | \$71,160 |
| Bureau of Indian Affairs General Assistance | | 7 | \$80,240 |
| CalFresh (Food Stamps) | | 8 | \$89,320 |
| National School Lunch Program (NSLP) | | | |
| Low-Income Home Energy Assistance Program (LIHEAP) | | | |
| Supplemental Security Income | | | |
| <small>¹ Includes Welfare-to-Work</small> | | For each additional household member, add \$9,080 *Includes current household income from all sources before deductions. | |

QUALIFICATION REQUIREMENTS:

- Completed and signed application.
- A copy of IRS letter granting tax-exempt status of corporation operating the facility under Internal Revenue Code Section 501(c)(3).
- Group living facility must provide a copy of license from appropriate state agency, conditional use permit for each facility, OR other adequate proof of eligibility.
- Each facility must meet the CARE guidelines shown in the income chart above.

Energy Savings Assistance ProgramSM

ENERGY SAVINGS ASSISTANCE PROGRAM

You may also qualify for home improvement services at no cost. Learn more at www.socalgas.com/improvements.

PLEASE FILL OUT AND PRINT PAGES
4 THROUGH 6
FOR 20% DISCOUNT CARE APPLICATION

20% DISCOUNT CARE APPLICATION

FOR QUALIFIED NONPROFIT GROUP LIVING FACILITIES



PRIMARY FACILITY ACCOUNT INFORMATION: (please print)

| | | | |
|---|----------------------|-----------------|----------------------|
| Name on natural gas bill: | <input type="text"/> | Account number: | <input type="text"/> |
| Name of facility (if different from name on natural gas bill): <input type="text"/> | | | |
| Service address: | <input type="text"/> | City: | <input type="text"/> |
| | | State: | <input type="text"/> |
| Mailing address: | <input type="text"/> | City: | <input type="text"/> |
| | | State: | <input type="text"/> |
| Primary contact: | <input type="text"/> | Email: | <input type="text"/> |
| Phone: | <input type="text"/> | Fax: | <input type="text"/> |

TYPE OF FACILITY

| | |
|--|--|
| <input type="checkbox"/> Group living facility, total number of residents at this facility: <input type="text"/> | Total number of residents who are qualified : <input type="text"/> (see Individual Eligibility Guidelines) |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Homeless shelter |
| <input type="checkbox"/> Women's shelter | Number of beds: <input type="text"/> |
| | Number of days occupied each year: <input type="text"/> |
| Other: <input type="text"/> | Total number of residents at this facility: <input type="text"/> |
| | Total number of residents who are qualified : <input type="text"/> (see Individual Eligibility Guidelines) |

PRIMARY SERVICES OFFERED BY THE FACILITY

| | | | | | |
|---|--------------------------------|---|-----------------------------------|-------------------------------------|-----------------------------|
| <input type="checkbox"/> Lodging | <input type="checkbox"/> Meals | <input type="checkbox"/> Rehabilitation | <input type="checkbox"/> Training | <input type="checkbox"/> Counseling | Other: <input type="text"/> |
| Is at least 70% of the natural gas used at the facility for residential purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| Does nonprofit corporation operation facility have a tax-exempt status under Internal Revenue Section 501(c)(3)? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| Is the facility government-owned or operated? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | | |
| Name of Business License (Please attach a copy of the State-Issued License or other adequate proof of eligibility for each facility): <input type="text"/> | | | | | |
| Name on Conditional Use Permit (Please attach a copy of the Conditional Use Permit or other adequate proof of eligibility for each facility): <input type="text"/> | | | | | |

ALL QUALIFIED SATELLITE FACILITIES (if applicable)

| | | | |
|--|--|--|--|
| Facility name: | <input type="text"/> | Account number: | <input type="text"/> |
| Service address: | <input type="text"/> | Satellite facility: | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> Group living facility | Total number of residents at this facility: <input type="text"/> | Total number of residents who are qualified : <input type="text"/> (see Individual Eligibility Guidelines) | |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Women's shelter | Number of beds: <input type="text"/> |
| | | | Number of days occupied each year: <input type="text"/> |
| Is at least 70% of the natural gas used at the facility for residential purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | |

20% DISCOUNT CARE APPLICATION

FOR QUALIFIED NONPROFIT GROUP LIVING FACILITIES



ALL QUALIFIED SATELLITE FACILITIES (continued)

| | | | | |
|--|--|--|--|---|
| Facility name: | <input type="text"/> | Account number: | <input type="text"/> | |
| Service address: | <input type="text"/> | Satellite facility: | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| <input type="checkbox"/> Group living facility | Total number of residents at this facility: <input type="text"/> | Total number of residents who are qualified : <input type="text"/> (see Individual Eligibility Guidelines) | | |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Women's shelter | Number of beds: <input type="text"/> | Number of days occupied each year: <input type="text"/> |
| Is at least 70% of the natural gas used at the facility for residential purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |

| | | | | |
|--|--|--|--|---|
| Facility name: | <input type="text"/> | Account number: | <input type="text"/> | |
| Service address: | <input type="text"/> | Satellite facility: | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| <input type="checkbox"/> Group living facility | Total number of residents at this facility: <input type="text"/> | Total number of residents who are qualified : <input type="text"/> (see Individual Eligibility Guidelines) | | |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Women's shelter | Number of beds: <input type="text"/> | Number of days occupied each year: <input type="text"/> |
| Is at least 70% of the natural gas used at the facility for residential purposes? <input type="checkbox"/> YES <input type="checkbox"/> NO | | | | |

CERTIFICATION OF ELIGIBILITY

I certify, under penalty of perjury, under the laws of the State of California, that the information on this application is true and accurate. I am authorized by this facility to sign this application, and I have verified the income eligibility of all residents. I am responsible for the renewal of the facility's license from the appropriate State Licensing Department, or for the Conditional Use Permit, or to provide adequate proof of eligibility. I understand that Southern California Gas Company may verify the accuracy of this information and confirm the direct benefit to the residents through random samplings. Errors in any information provided may cause the account(s) to be re-billed without the CARE discount.

NOTICE TO CUSTOMER: Signing this application allows SoCalGas to share your CARE information with other utilities, so that you may receive their discount, if applicable.

| | | | |
|--|----------------------|-------|----------------------|
| Authorized representative's name and title (please print): | <input type="text"/> | | |
| Authorized representative's signature: | <input type="text"/> | Date: | <input type="text"/> |
| Authorized representative's telephone number: | <input type="text"/> | | |

Return to:
SoCalGas
CARE PROGRAM GT19A1
P.O. Box 513249
Los Angeles, CA 90051-1249