



A  Sempra Energy utility®

20% DISCOUNT CARE APPLICATION

The California Alternate Rates for Energy (CARE) program offers eligible SoCalGas® customers a 20 percent discount on their monthly natural gas bill. The discount will be applied to the monthly natural gas 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
- 2)** Call 866-716-3452 anytime, 24 hours a day. Please have your SoCalGas 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

The individual resident in the facility 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

OR

¹Includes Welfare-to-Work

MAXIMUM HOUSEHOLD INCOME

(effective June 1, 2019 to May 31, 2020)

Number of Persons in Household

Total Annual Income*

1-2

\$33,820

3

\$42,660

4

\$51,500

5

\$60,340

6

\$69,180

7

\$78,020

8

\$86,860

For each additional household member, add \$8,840

*Includes current household income from all sources before deductions.

CONDITIONS FOR PARTICIPATION:

- 1)** You must meet the qualification requirements in the table above.
- 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

Receive energy-saving home improvements at no cost that 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 BILL

Bill payment assistance, emergency bill assistance and weatherization services

LOW INCOME HOME ENERGY ASSISTANCE

1-866-675-6623



HELP WITH YOUR PHONE

Discounted telephone services for eligible customers

CALIFORNIA LIFELINE

For more information contact your telephone service provider

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

N19E0042A 0619

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 - \$33,820
- \$33,821 - \$42,660
- \$42,661 - \$51,500
- \$51,501 - \$60,340
- \$60,341 - \$69,180
- If more than \$69,180, 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:

DATE: / /