



A Sempra Energy utility

CUSTOMER ASSISTANCE

**20% DISCOUNT  
CARE APPLICATION**

Through the California Alternate Rates for Energy (CARE) program, SoCalGas® offers a 20 percent discount to eligible customers on their monthly gas bill. Eligible customers who are approved within 90 days after starting new gas service will also receive a \$15 discount on the Service Establishment Charge. The discount will be applied to the monthly 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 complete and return the following application by mail, fax, or apply online at [socialgas.com](http://socialgas.com) (Search "CARE").

**THERE ARE TWO WAYS TO QUALIFY**

<b>PUBLIC ASSISTANCE PROGRAMS</b> If you or another person in your household receives benefits from any of the following programs:	<b>MAXIMUM HOUSEHOLD INCOME</b> (effective June 1, 2015 to May 31, 2016)	
	Number of Persons in Household	Total Annual Income*
Medi-Cal/Medicaid	1-2	\$31,860
Medi-Cal for Families A & B	3	\$40,180
Women, Infants, & Children (WIC)	4	\$48,500
CalWORKs (TANF) <sup>1</sup> / Tribal TANF	5	\$56,820
Head Start Income Eligible – Tribal Only	6	\$65,140
Bureau of Indian Affairs General Assistance	7	\$73,460
CalFresh (Food Stamps)	8	\$81,780
National School Lunch Program (NSLP)	For each additional household member, add \$8,320 *Includes current household income from all sources before deductions.	
Low-Income Home Energy Assistance Program (LIHEAP)		
Supplemental Security Income (SSI)		



**CONDITIONS FOR PARTICIPATION**

- 1) The natural gas bill must be in your name and the address must be your primary address.
- 2) You must not be claimed as a dependent on another person's income tax return other than your spouse.
- 3) You must recertify your application when requested.
- 4) You must notify SoCalGas within 30 days if you no longer qualify.
- 5) 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 attic insulation, low-flow showerheads, faucet aerators, door weather-stripping, caulking and minor home repairs to eligible income-qualified 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.

**Low Income Home Energy Assistance Program (LIHEAP):** 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 MORE INFORMATION ON CUSTOMER ASSISTANCE:**

English: 1-800-427-2200      한국어: 1-800-427-0471      廣東話: 1-800-427-1429  
 中文: 1-800-427-1420      Español: 1-800-342-4545      Việt: 1-800-427-0478  
 FAX: (213) 244-4665  
 Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)

# 20% DISCOUNT CARE APPLICATION

PLEASE USE DARK BLUE OR BLACK INK ONLY

Please complete and return the application by mail, fax, or apply online at **socalgas.com** (Search "CARE").

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

ACCOUNT NUMBER/FACILITY I.D.

PLEASE PROVIDE YOUR ACCOUNT NUMBER OR FACILITY I.D. TO EXPEDITE PROCESSING.

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

ADDRESS

APT/SPACE #

CITY

HOME PHONE

EMAIL

## 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 (SSI)

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

- \$0 - \$31,860
- \$31,861 - \$40,180
- \$40,181 - \$48,500
- \$48,501 - \$56,820
- \$56,821 - \$65,140
- If more than \$65,140, enter the dollar amount here  
\$  ,  .00 per year.

### 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 profit from self employment
- 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 or other income

## 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 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:

DATE:  /  /