

PUBLIC UTILITIES COMMISSION

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July 10, 2009

Advice Letter 3988

Ronald van der Leeden, Director
Rates, Revenues and Tariffs
8330 Century Park Court CP32C
San Diego, CA 92123-1548

**Subject: Revised Application Forms and Instructions for the California
Alternate Rates for Energy (CARE) Program**

Dear Mr. van der Leeden:

Advice Letter 3988 is effective June 1, 2009.

Sincerely,

A handwritten signature in blue ink, appearing to read "Julie A. Fitch".

Julie A. Fitch, Director
Energy Division



Ronald van der Leeden
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May 14, 2009

Advice No. 3988
(U 904 G)

Public Utilities Commission of the State of California

Subject: Revised Application Forms and Instructions for the California Alternate Rates for Energy (CARE) Program

Southern California Gas Company (SoCalGas) hereby submits for filing revisions to its tariff forms, applicable throughout its service territory, as shown on Attachment B.

This filing is made in compliance with Ordering Paragraph (OP) 3 of Resolution (Res.) E-3524, dated February 19, 1998.

Purpose

This filing revises SoCalGas' effective period for the income-qualified rate schedules that reflect the income-eligibility guidelines used to qualify individuals or households for the CARE program. The income-eligibility levels effective from June 1, 2009, through May 31, 2010, remain unchanged from the previous period. This filing contains nine application forms: qualified agricultural employee housing, general purpose bilingual direct mail, individually metered self-certification in 13 languages, individually metered self-recertification in five languages, bilingual form for the Capitation program, post-enrollment verification in five languages, sub-metered bilingual self-certification, sub-metered bilingual self-recertification, and bilingual bill insert.

Information

Res. E-3524 authorizes the energy utilities to change the income-eligibility guidelines for the CARE program pursuant to a communication issued by the Director of the Energy Division by May 1st of each year, with tariff revisions to be filed and become effective June 1st of each year. Pursuant to a notice dated April 28, 2009, from the Director of the Energy Division, SoCalGas was provided with the new CARE income-eligibility levels to be effective from June 1, 2009, through May 31, 2010. The Energy Division has determined that the new income levels are increased by 0.001% and rounded to the nearest 100; however, based on the new income levels, the income guidelines remain unchanged. This notice further directs the energy utilities to file revised tariffs with the Energy Division reflecting the new effective period by May 14, 2009.

This filing will not increase any rate or charge, cause the withdrawal of service, or conflict with any rate schedule or rule.

Protest

Anyone may protest this Advice Letter to the California Public Utilities Commission. The protest must state the grounds upon which it is based, including such items as financial and service impact, and should be submitted expeditiously. The protest must be made in writing and received within 20 days of the date of this Advice Letter. There is no restriction on who may file a protest. The address for mailing or delivering a protest to the Commission is:

CPUC Energy Division
Attention: Tariff Unit
505 Van Ness Avenue
San Francisco, CA 94102

Copies of the protest should also be sent via e-mail to the attention of both Maria Salinas (mas@cpuc.ca.gov) and Honesto Gatchalian (hnj@cpuc.ca.gov) of the Energy Division. A copy of the protest should also be sent via both e-mail and facsimile to the address shown below on the same date it is mailed or delivered to the Commission.

Attn: Sid Newsom
Tariff Manager - GT14D6
555 West Fifth Street
Los Angeles, CA 90013-1011
Facsimile No. (213) 244-4957
E-mail: snewsom@SempraUtilities.com

Effective Date

SoCalGas believes that this filing is subject to Energy Division disposition and should be classified as Tier 1 (effective pending disposition) pursuant to GO 96-B. In compliance with OP 3 of Res. E-3524, dated February 19, 1998, and the April 22, 2008, notice from the Energy Division, the tariff sheets filed herein are to be effective for service on and after June 1, 2009.

Notice

A copy of this advice letter is being sent to the parties listed on Attachment A, which includes the service list for R.08-07-011.

Ronald van der Leeden
Director
Rates, Revenues, and Tariffs

Attachments

CALIFORNIA PUBLIC UTILITIES COMMISSION

ADVICE LETTER FILING SUMMARY ENERGY UTILITY

MUST BE COMPLETED BY UTILITY (Attach additional pages as needed)

Company name/CPUC Utility No. **SOUTHERN CALIFORNIA GAS COMPANY (U 904-G)**

Utility type:

ELC GAS
 PLC HEAT WATER

Contact Person: Sid Newsom

Phone #: (213) 244-2846

E-mail: snewsom@semprautilities.com

EXPLANATION OF UTILITY TYPE

ELC = Electric GAS = Gas
PLC = Pipeline HEAT = Heat WATER = Water

(Date Filed/ Received Stamp by CPUC)

Advice Letter (AL) #: 3988

Subject of AL: Revised Application Forms and Instructions for the California Alternate Rates for Energy (CARE) Program

Keywords (choose from CPUC listing): CARE, Forms

AL filing type: Monthly Quarterly Annual One-Time Other _____

AL filed in compliance with a Commission order, indicate relevant Decision/Resolution #:
E-3524

Does AL replace a withdrawn or rejected AL? If so, identify the prior AL No

Summarize differences between the AL and the prior withdrawn or rejected AL¹: N/A

Does AL request confidential treatment? If so, provide explanation: No

Resolution Required? Yes No

Tier Designation: 1 2 3

Requested effective date: June 1, 2009

No. of tariff sheets: 11

Estimated system annual revenue effect (%): None

Estimated system average rate effect (%): None

When rates are affected by AL, include attachment in AL showing average rate effects on customer classes (residential, small commercial, large C/I, agricultural, lighting).

Tariff schedules affected: Sample Forms and TOCs

Service affected and changes proposed¹: N/A

Pending advice letters that revise the same tariff sheets: _____

Protests and all other correspondence regarding this AL are due no later than 20 days after the date of this filing, unless otherwise authorized by the Commission, and shall be sent to:

CPUC, Energy Division

Attention: Tariff Unit

505 Van Ness Ave.

San Francisco, CA 94102

mas@cpuc.ca.gov and jnj@cpuc.ca.gov

Southern California Gas Company

Attention: Sid Newsom

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¹ Discuss in AL if more space is needed.

ATTACHMENT A

Advice No. 3988

(See Attached Service List)

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<p>CALIF PUBLIC UTILITIES COMMISSION Sazedur Rahman snr@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Rashid A. Rashid rhd@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Thomas Roberts tcr@cpuc.ca.gov</p>
<p>CALIFORNIA ENERGY COMMISSION IRENE SALAZAR isalazar@energy.state.ca.us</p>	<p>SOUTHERN CALIFORNIA EDISON COMPANY STACIE SCHAFFER stacie.schaffer@sce.com</p>	<p>PETER SCHWARTZ & ASSOCIATES, LLC PETER M. SCHWARTZ pmschwartz@sbcglobal.net</p>
<p>SCHWEITZER AND ASSOCIATES, INC. JUDI G. SCHWEITZER judi.schweitzer@post.harvard.edu</p>	<p>CHRIS SCRUTON cscruton@energy.state.ca.us</p>	<p>CALIFORNIA ENERGY COMMISSION MARGARET SHERIDAN msherida@energy.state.ca.us</p>
<p>CLEAREDGE POWER CORPORATION JON W. SLANGERUP js@clearedgepower.com</p>	<p>CITY AND COUNTY OF SAN FRANCISCO JEANNE M. SOLE jeanne.sole@sfgov.org</p>	<p>MARAVILLE FOUNDATION ALEX SOTOMAYOR alexst@aol.com</p>
<p>GOODIN MACBRIDE SQUERI DAY & LAMPREYLLP JAMES SQUERI jsqueri@gmssr.com</p>	<p>CALIFORNIA CENTER FOR SUSTAINABLE ENERGY IRENE STILLINGS irene.stillings@energycenter.org</p>	<p>BEAR VALLEY ELECTRIC SERVICE KEITH SWITZER kswitzer@gswater.com</p>
<p>CALIF PUBLIC UTILITIES COMMISSION Don Schultz dks@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Yuliya Shmidt ys2@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Joyce Steingass jws@cpuc.ca.gov</p>
<p>HELLER MANUS ARCHITECTS REMI TAN RemiT@hellermanus.com</p>	<p>SILICON VALLEY LEADERSHIP GROUP FRANK TENG 224 AIRPORT PARKWAY, SUITE 620 SAN JOSE, CA 95110</p>	<p>SOCALGAS AND SDG&E MICHAEL R. THORP mthorp@sempra.com</p>
<p>ICE ENERGY, INC. GREG TROPSA gtropsa@ice-energy.com</p>	<p>CALIF PUBLIC UTILITIES COMMISSION George S. Tagnipes jst@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Zenaida G. Tapawan-Conway ztc@cpuc.ca.gov</p>
<p>CALIF PUBLIC UTILITIES COMMISSION Matthew Tisdale mwt@cpuc.ca.gov</p>	<p>CALIF PUBLIC UTILITIES COMMISSION Ava N. Tran atr@cpuc.ca.gov</p>	<p>TELACU RICHARD VILLASENOR richvilla4@hotmail.com</p>
<p>CALIF PUBLIC UTILITIES COMMISSION Christopher R Villarreal crv@cpuc.ca.gov</p>	<p>MODESTO IRRIGATION DISTRICT JOY A. WARREN joyw@mid.org</p>	<p>AGLET CONSUMER ALLIANCE JAMES WEIL jweil@aglet.org</p>

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swentworth@oaklandnet.com

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ASSOCIATION OF CALIFORNIA
WATER AGENCIES
910 K STREET, SUITE 100
SACRAMENTO, CA 95814-3577

ATTACHMENT B
Advice No. 3988

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 44706-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY (CARE) PROGRAM FOR QUALIFIED , AGRICULTURAL EMPLOYEE HOUSING (Form 6632-B, 06/09)	Revised 43440-G
Revised 44707-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - GENERAL PURPOSE, DIRECT MAIL (Form No. 6491-DMB, 05/09)	Revised 43441-G
Revised 44708-G	SAMPLE FORMS: APPLICATIONS, Self- Certification CARE Application, Individually Metered Residential (Form No. 6491-B, 06/09)	Revised 43791-G
Revised 44709-G	SAMPLE FORMS: APPLICATIONS, Self- Recertification CARE Application, Individually Metered Residential (Form No. 6674-B, 06/09)	Revised 43443-G
Revised 44710-G	SAMPLE FORMS: APPLICATIONS, Capitation Program CARE Application, (Form No. 6491-2B, 05/09)	Revised 43444-G
Revised 44711-G	SAMPLE FORMS: APPLICATIONS, Post- Enrollment Verification CARE Application, Individually Metered Residential (Form No. 6675- B, 06/09)	Revised 43445-G
Revised 44712-G	SAMPLE FORMS: APPLICATIONS, Self- Certification CARE Application, Submetered Residential (Form No. 6677-B, 06/09)	Revised 43446-G
Revised 44713-G	SAMPLE FORMS: APPLICATIONS, Self- Recertification CARE Application, Submetered Residential (Form No. 6678-B, 06/09)	Revised 43447-G
Revised 44714-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - BILL INSERT, (Form No. 6491- BI, 05/09)	Revised 43448-G
Revised 44715-G	TABLE OF CONTENTS	Revised 44440-G
Revised 44716-G	TABLE OF CONTENTS	Revised 44705-G

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY (CARE) PROGRAM FOR QUALIFIED
AGRICULTURAL EMPLOYEE HOUSING (Form 6632-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



Application for California Alternate Rates for Energy (CARE) Program For Qualified Agricultural Employee Housing Facilities



INSTRUCTIONS

1. PLEASE READ ALL information and instructions before you complete, sign, and date this application. If you have questions, call 1-800-207-8567, Monday through Friday, 7:00 am-4:00 pm.
2. DETERMINE if the facility meets the definition of a qualified agricultural employee housing facility. The facility MUST meet ALL criteria to qualify for the 20% discount from the CARE Program.
3. COMPLETE the entire application (please print or type). Complete a separate application for each qualified facility (including satellite facilities).
4. ATTACH all required documents. (Application is considered incomplete without documents).
5. MAIL to:

The Gas Company®
 CARE Program - ML 12F1
 PO Box 3249
 Los Angeles, CA 90051-1249

DISCOUNT

The CARE program provides a 20% discount off the utility bill for facilities that meet program criteria. The discount and eligibility criteria were established by the California Public Utilities Commission. The discounted rates, upon formal approval by the California Public Utilities Commission, are available to qualified facilities. The facility will receive the discount after the utility receives and approves the completed and signed application.

ELIGIBILITY CRITERIA FOR APPLICANT

Each applicant MUST meet all of the following criteria:

- Applicant must be the utility customer of record.
- Applicant must verify that 100% of the residents and/or households meet the current CARE eligibility shown below, excluding any employee operating or managing the facility who resides at the facility.

PUBLIC ASSISTANCE PROGRAMS:
If another person in the household receives benefits from any of the following programs:
Medi-Cal Food Stamps TANF(AFDC) Women, Infant & Children (WIC) Healthy Families Categories A&B LIHEAP

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2009 to May 31, 2010)</i>	
Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Each Additional household member, add	\$7,400

- Applicant is required to certify CARE eligibility annually by completing a new application, including how the discount will be used in the first year for the direct benefit of the residents.

ELIGIBLE FACILITIES

Employee Housing (privately owned), as defined in section 17008 of the Health and Safety Code, that is licensed and inspected by state and/or local agencies pursuant to Part I (commencing with Section 17000) of Division 13.

- Supporting documentation required:
 - ✓ Provide copy of current permit issued by the Department of Housing and Community Development.
- Total energy used must be 100% residential.

Housing for Agricultural Employees (non-migrant and operated by non-profit entities), as defined in Subdivision (b) of Section 1140.4 of the Labor Code, that has an exemption from local property taxes pursuant to subdivision (g) of Section 214 of the Revenue and Taxation Code.

- Supporting documentation required:
 - ✓ Provide current copy of federal 501(c) (3) tax exemption or copy of state tax exemption form, and current copy of local property tax exemption form.
- Total Energy used:
 - ✓ Master-metered facilities must be 70% residential use.
 - ✓ Individually metered units must be 100% residential use.

APPLICANTS RESPONSIBILITIES

The applicant is required to:

- Provide proof of facility's eligibility (see Eligible Facilities) and submit required documentation with the application (see requirements on the application).
- Verify that all individuals residing in the facility meet the CARE eligibility (see Eligibility Criteria for Applicant) and make a certification to that effect, under penalty of perjury, under the laws of the state of California.
- At annual recertification, show how the past year's discount was used and how the next year's discount is expected to be used for direct benefit of the residents.
- Maintain records of residents' CARE eligibility, which should come from federal tax return, payroll stubs or similar records acceptable to the utility. These records must be retained for three (3) years from the date of initial application and/or recertification.
- Maintain accounting entries and supporting documentation of how the discount was used for the direct benefit of the residents. These records must be retained for three (3) years from the date of initial application and/or recertification.
- Upon request from the utility, provide documentation of the residents' CARE eligibility and/or documentation of how the discount was used for the direct benefit of the residents.
- Provide all information requested by the utility. Failure to do so will result in denial or removal from the program. The applicant may be subject to rebilling for the period they were ineligible for the discount as determined by the utility.

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM - GENERAL PURPOSE
DIRECT MAIL (Form No. 6491-DMB, 05/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



A Sempra Energy utility®

CARE

20% DISCOUNT

Dear Customer,

Through our California Alternate Rates for Energy (CARE) program, The Gas CompanySM offers a 20% discount for customers who meet certain requirements. This program is helping people save money every month, so perhaps it could help you too.

To see if you qualify, check the requirements listed below. The income qualifications are based on current income for the total number of people living in your household. If you are recently unemployed, you may now be eligible for our CARE program. If you think you meet the requirements, just fill out the application on the back of this letter and mail it back to us in the postage-paid envelope provided.

If you do not qualify for the CARE program, but know someone who might, please share this with them.

THERE ARE TWO WAYS TO QUALIFY FOR THE CARE DISCOUNT:

1 PUBLIC ASSISTANCE PROGRAMS:

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

- Medi-Cal
- Food Stamps
- TANF(AFDC)
- Women, Infants & Children (WIC)
- Healthy Families Categories A&B
- LIHEAP

2 MAXIMUM HOUSEHOLD INCOME:

(effective June 1, 2009 to May 31, 2010)

Number of Persons in Household	Total Annual Income*
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000

←OR→

For each additional household member, add \$7,400

* Includes current household income from all sources before deductions.

CONDITIONS FOR PARTICIPATION

1) The gas bill must be in your name and the address must be your primary address. 2) You may not be claimed as a dependent on another person's income tax return other than your spouse's. 3) You will need to recertify your application when requested. 4) You are required to notify The Gas Company within 30 days if you no longer qualify. 5) You may be asked to verify your eligibility for CARE.

At The Gas Company, we are committed to providing safe and reliable energy to all our customers and we strive to provide exceptional service. If you have any questions or would like more information about our assistance programs, please call us at 1-800-427-2200 or apply online at www.socalgas.com/assistance/.

Sincerely,

Kirk Morales

CARE Program Sr. Market Advisor



A Semptra Energy utility®

CARE APPLICATION

FOR A 20% DISCOUNT

To qualify for the 20% discount, please complete the application form and return it to The Gas Company. You will receive your discount once your completed, signed application is approved by The Gas Company.

NAME:

ADDRESS:

CITY/ZIP:

ACCOUNT #:

EMAIL:

PLEASE COMPLETE IN BLACK OR DARK BLUE INK.

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

HOME PHONE: - -

2A Public Assistance Programs Benefits Received

If you or someone in your household receives benefits from any of the programs below, please fill in the circle(s) ●, and go directly to 3.

- Medi-Cal: Under 65 years of age
- Medi-Cal: 65 years or older
- Food Stamps
- TANF (AFDC)
- Healthy Families A&B
- LIHEAP
- WIC

If NONE of the above, please complete Section 2B

2B Household Income Information: Skip if you completed Section 2A

Part 1: If you do not participate in any of the programs listed above, please fill in the circle(s) ● for all sources of income in your household, and indicate your total household income in the spaces provided below:

- Social Security
- Pensions
- SSI, SSP, SSDI
- Interest or Dividends from:
 - Savings Accounts, Pensions
 - Stocks or Bonds
 - Retirement Accounts
- Wages or Salaries
- Legal Settlements
- Unemployment Benefits
- Insurance Settlements
- Disability Payments
- Spousal Support
- Workers Compensation
- Child Support
- Cash and/or other income
- Scholarships, Grants, or Other Aid Used for Living Expenses
- Rental or Royalty Income
- Profit from Self-Employment, (IRS Form 1040, Schedule C, line 29)

Part 2: Please fill in the circle ● of your household's current income range per year before deductions.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000
- If more than \$58,000, enter the dollar amount here: \$, .00 per year

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 The Gas Company if I no longer qualify to receive the 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 The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs.

SIGNATURE:

X

DATE:

/ /

Please don't forget to include your signature.
Mail this application in the postage-paid envelope provided to:

THE GAS COMPANY CARE PROGRAM
PO Box 515005
Los Angeles CA 90099-9316
Southern California Gas Company - Source Code 94



A Sempra Energy utility®

CARE

20% DE DESCUENTO

Estimado Cliente:

Por medio de nuestro programa Tarifas Alternas para Energía de California (CARE), The Gas CompanySM ofrece un 20% de descuento a los clientes que reúnen ciertos requisitos en el hogar. Este programa está ayudando a personas a ahorrar dinero mensualmente, así que tal vez le podría ayudar a usted también.

Para saber si califica, revise los requisitos que se presentan a continuación. Los requisitos de ingreso se basan en el ingreso total actual del número de personas que viven en su hogar. Si usted está actualmente desempleado, usted ahora puede tener derecho al programa CARE. Si cree usted que califica, entonces sólo llene la solicitud detrás de esta carta y envíenosla por correo en el sobre con timbre pagado por adelantado.

Si no reúne los requisitos del programa CARE, pero conoce alguien que tal vez califique, favor de compartir esta información con ellos.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

1 PROGRAMAS DE ASISTENCIA PÚBLICA:

Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:

- Medi-Cal
- Food Stamps
- TANF(AFDC)
- Women, Infants & Children (WIC)
- Healthy Families Categories A&B
- LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)

2 INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)

Número de personas en el hogar	Ingreso total anual*
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000



Por cada miembro adicional en el hogar, añada \$7,400
* Incluye los ingresos actuales del hogar de todas las fuentes de ingreso antes de deducciones.

CONDICIONES PARA PARTICIPAR

- 1) La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal.
- 2) No puede aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge.
- 3) Debe recertificar su solicitud CARE cuando se le solicite.
- 4) Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- 5) Tal vez se le pida comprobar que reúne los requisitos para CARE.

En The Gas Company, estamos comprometidos a proveer energía segura y confiable a nuestros clientes y nos esforzamos por proveer un excepcional servicio al cliente. Si tiene preguntas o quisiera más información acerca de nuestros programas de ayuda, por favor llámenos al 1-800-342-4545 ó aplique en línea en www.socalgas.com/sp/asistencia/.

Atentamente,

Kirk Morales
Gerente del programa CARE



A Semptra Energy utility®

SOLICITUD CARE PARA UN 20% DE DESCUENTO

Para tener derecho al 20% de descuento, por favor llene el formulario de solicitud y regréselo a The Gas Company. Recibirá su descuento una vez que su solicitud llena y firmada sea aprobada por The Gas Company.

NOMBRE:

DOMICILIO:

CIUDAD/CÓDIGO POSTAL:

NÚMERO DE CUENTA:

CORREO ELECTRÓNICO:

POR FAVOR DE COMPLETAR EN TINTA NEGRA O AZUL OSCURA.

1 Número total de personas que viven en su hogar (inclúyase usted, otros adultos y niños):

TELEFÓNO DE CASA:

2A Beneficios que recibe a través de programas de asistencia pública: Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas siguientes, por favor rellene el/los círculo/s ● y vaya directamente a la sección 3.

- Medi-Cal: menor de 65 años
- Medi-Cal: 65 años o más
- Food Stamps
- TANF (AFDC)
- Healthy Families A&B
- LIHEAP
- WIC

Si no marcó NINGUNO, sírvase llenar la sección 2B

2B Ingreso anual de su hogar: Si llenó la sección 2A, vaya directamente a la sección 3.

Parte 1: Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el/los círculo/s ● para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- Seguro Social
- Pensiones
- SSI, SSP, SSDI
- Intereses o dividendos de:
 - Cuentas de ahorro, pensiones
 - Acciones o bonos
 - Cuentas para el retiro
- Salarios o sueldos
- Pagos de reclamaciones legales
- Beneficios de desempleo
- Pagos de reclamaciones a seguros
- Pagos de incapacidad
- Pensión conyugal
- Indemnización para los trabajadores
- Pensión alimenticia
- Dinero en efectivo y/u otros ingresos
- Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- Ingresos por alquiler o regalías
- Utilidades de autoempleo, (Formulario 1040, Anexo C, Renglón 29 del IRS)

Parte 2: Sírvase rellenar el círculo ● de la gana que corresponde al ingreso anual actual de su hogar antes de deducciones.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000
- Si es más de \$58,000, escriba la suma anual: \$, .00

3 Declaración: Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Si se me solicita, convengo en presentar comprobantes de que reúno los requisitos de CARE. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia.

FIRMA: X

FECHA:

Por favor no olvide su firma.
Envíe ésta solicitud por correo en el sobre con timbre pagado por adelantado a:

THE GAS COMPANY CARE PROGRAM
PO Box 515005
Los Angeles CA 90099-9316
Southern California Gas Company - Source Code 92

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Individually Metered Residential (Form No. 6491-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



A Sempra Energy utility

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY APPLICATION

The Gas Company's California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households. Those who qualify and are approved within 90 days of starting new gas service will also receive a \$15 discount on the Service Establishment Charge. Please complete this form and return within 90 days or apply online at <http://www.socalgas.com/residential/assistance/care/index.shtml>

To see if you qualify, check the requirements shown below. Please complete the application and return it in the envelope provided. The discount will be applied once your completed and signed application is approved by The Gas CompanySM.

THERE ARE 2 WAYS TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or another person in your household receives benefits from any of the following programs:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2009 to May 31, 2010)</i>	
Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Each Additional household member, add	\$7,400

CONDITIONS FOR PARTICIPATION

- The gas bill must be in your name and the address must be your primary address.
- You must not be claimed as a dependent on another person's income tax return other than your spouse.
- You must recertify your application when requested.
- You must notify The Gas Company within 30 days if you no longer qualify.
- You may be asked to verify your eligibility for CARE.

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

- **DAP** - Direct Assistance Program, a low income energy efficiency program, offers free energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repair. 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.
- **LIHEAP** - Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Department of Community Services and Development at 1-866-675-6623.
- **California Lifeline (ULTS)** - A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English: 1-800-427-2200	Mandarin: 1-800-427-1429	Spanish: 1-800-342-4545
Korean: 1-800-427-0471	Cantonese: 1-800-427-1420	Vietnamese: 1-800-427-0478

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)



CARE 20% Rate Discount Application

(Please use dark ink and print clearly to ensure proper processing)

Form 6491-B (06/09) EN

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Account Number:

Date: 06/01/2009

Customer Name:

Address:

1 Total number in your household (including yourself, other adults, and children):

↓
Home Phone #: - -

2A **Public Assistance Programs Benefits Received:**
If you or someone in your household receives benefits from any of the programs below, please fill in the circle (●), then go directly to **3**.

- Medi-Cal: Under 65 of age Food Stamps Healthy Families A&B WIC
 Medi-Cal: 65 or older TANF (AFDC) LIHEAP

OR

*If NONE of the above, please complete section **2B**.*

2B **Household Income: Skip if you completed section **2A**.**
Part 1: If you do not participate in any of the programs listed above, please fill in the circle (●) for all sources of income in your household, and provide your total household income in the spaces provided below:

- | | | |
|--|---|--|
| <input type="radio"/> Social Security | <input type="radio"/> Wages or Salaries | <input type="radio"/> Legal Settlements |
| <input type="radio"/> Pensions | <input type="radio"/> Unemployment Benefits | <input type="radio"/> Insurance Settlements |
| <input type="radio"/> SSI, SSP, SSDI | <input type="radio"/> Disability Payments | <input type="radio"/> Spousal Support |
| Interest or Dividends from: | <input type="radio"/> Workers Compensation | <input type="radio"/> Child Support |
| <input type="radio"/> Savings Accounts, Pensions | <input type="radio"/> Scholarships, Grants, or Other Aid Used for Living Expenses | <input type="radio"/> Cash and/or other income |
| <input type="radio"/> Stocks or Bonds | | <input type="radio"/> Rental or Royalty Income |
| <input type="radio"/> Retirement Accounts | | <input type="radio"/> Profit from Self-Employment (IRS Form 1040, Schedule C, line 29) |

Part 2: Please fill in the circle (●) of your household's income range per year before deductions.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

If more than \$58,000, enter amount here: \$, .00 per year

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 The Gas Company if I no longer qualify to receive the 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 The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs.

Signature: X **Date:**

**FORMULARIO DE SOLICITUD
PARA EL DESCUENTO DEL 20%****SOLICITUD PARA EL PROGRAMA DE TARIFAS ALTERNAS PARA ENERGÍA EN CALIFORNIA**

El programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM ofrece un descuento del 20% en la factura mensual de gas a los hogares que reúnen los requisitos. Aquellos que califiquen y sean aprobados en un término de 90 días a partir del inicio de su servicio de gas también recibirán un descuento de \$15 en el Cargo de Conexión de Servicio (Service Establishment Charge).

Para ver si califica, revise los requisitos que aparecen a continuación. Sírvase llenar el formulario de solicitud y regresarlo en el sobre provisto ó aplique en-línea a <http://socalgas.com/sp/residential/assistance/care/index.html>. El descuento se aplicará una vez que el formulario de solicitud debidamente llenado y firmado haya sido aprobado por The Gas Company.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:	INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)</i>	
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:	Número de personas en el hogar	Ingreso total anual
Medi-Cal	1-2	\$30,500
Food Stamps	3	\$35,800
TANF(AFDC)	4	\$43,200
Women, Infants & Children (WIC)	5	\$50,600
Healthy Families Categories A&B	6	\$58,000
LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)	Por cada miembro adicional en el hogar, añada	\$7,400

O

CONDICIONES PARA PARTICIPAR

- La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal.
- No debe aparecer como dependiente en la declaración de impuestos de otra persona que no sea su cónyuge.
- Debe recertificar su solicitud cuando se le solicite.
- Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- Tal vez se le pida comprobar que reúne los requisitos para CARE.

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE QUIZÁ PUDIERA CALIFICAR:

- **Programa de Asistencia Directa (DAP):** Este programa de eficiencia energética para clientes de bajos recursos ofrece mejoras gratuitas para el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a fin de ahorrar energía. Para más información, llame al 1-800-331-7593.
- **Asignación Médica Inicial (Medical Baseline):** Provee asignación adicional de gas a una tarifa menor a los clientes con ciertas afecciones médica. Para más información, llame al 1-800-342-4545.
- **Programa de Ayuda Energética para Hogares de Bajos Recursos (LIHEAP):** Ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y servicios de acondicionamiento contra las inclemencias del tiempo. Llame al Departamento de Servicios a la Comunidad de California al 1-866-675-6623.
- **Servicio Telefónico Universal Lifeline (California Lifeline-ULTS):** Acceso telefónico a precios de descuento para los clientes que reúnan requisitos de ingreso similares a los del programa CARE. Para más información, llame al proveedor de servicio telefónico de su localidad.

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200
Coreano: 1-800-427-0471

Mandarín: 1-800-427-1429
Cantonés: 1-800-427-1420

Español: 1-800-342-4545
Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)



Formulario de solicitud para la tarifa CARE del 20% de descuento

Form 6491-B (06/09) SP

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



(Por favor use tinta oscura y escriba claramente con letra de molde para asegurar el procesamiento apropiado)

Número de cuenta:

Fecha: 06/01/2009

Nombre del cliente:

Domicilio:

1 Número total de personas que viven en su hogar (incluidos usted, otros adultos y niños):

↓
Teléfono de casa: - -

2A

Beneficios que recibe a través de programas de asistencia pública:

Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas demostrados, por favor rellene el círculo (●), y vaya directamente a la sección **3**.

- Medi-Cal: menor de 65 años Food Stamps Healthy Families A&B WIC
- Medi-Cal: 65 años o más TANF (AFDC) LIHEAP

O

Si no marcó NINGUNO, sírvase llenar la sección **2B.**

2B

Ingreso en el hogar: Sáteselo si llenó la sección **2A.**

Parte 1: Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el círculo (●) para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- Seguro Social Salarios o sueldos Pagos de reclamaciones legales
- Pensiones Beneficios de desempleo Pagos de reclamaciones a seguros
- SSI, SSP, SSDI Pagos de incapacidad Pensión conyugal
- Intereses o dividendos de: Indemnización para Pensión alimenticia
 - Cuentas de ahorro, Pensiones los trabajadores Dinero en efectivo y/u otros ingresos
 - Acciones o bonos Becas, subvenciones Ingresos por alquiler o regalías
 - Cuentas para el retiro u otra ayuda usada Utilidades de autoempleo (Formulario 1040, Anexo C, Renglón 29 del IRS)

Parte 2: Sírvase rellenar el círculo (●) que corresponde al rango del ingreso anual de su hogar antes de deducciones.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000
- Si es más de \$58,000, escriba el monto aquí: \$, .00 al año

3 Declaración: Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia con requisitos de ingreso.

Firma : X

Fecha:



加州能源優惠率計劃申請

The Gas CompanySM (瓦斯公司) 的加州能源優惠率 (CARE) 計劃提供符合特定資格的家庭 20% 的瓦斯 (煤氣) 費折扣。如果您在開新的瓦斯服務的 90 天之內申請並通過審核, 還可獲得 \$15 的開戶手續費優惠。

查看您是否符合資格, 請核對下列必要條件。請您填妥申請表格並用所提供的郵資已付信封寄回。在 The Gas Company 核准您填寫並簽名的申請表後, 您即可享受折扣。

符合 CARE 折扣的兩種資格:

政府協助計劃:
如果您或您的家人從下列任一計劃中受益
Medi-Cal - 加州醫療輔助計劃
Food Stamps - 食物券
TANF(AFDC) - 貧困家庭臨時現金資助計劃
Women, Infants & Children (WIC) - 婦女、嬰兒和兒童營養輔助計劃)
Healthy Families Categories A&B - 健康家庭低費兒童醫療健保計劃類別 A 及 B
LIHEAP - 低收入家庭能源協助計劃

或

家庭收入最高限額: (有效期 2009 年 6 月 1 日至 2010 年 5 月 31 日)	
家庭成員人數	年收入總額
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
每多一位家庭成員, 增加	\$7,400

參加條件

- 瓦斯帳單必須在您的名下並且地址必須為您的主要住宅。
- 除您配偶外, 您不能是其他人報稅單上的被撫養人。
- 您必須在被要求時, 重新認證您還符合 CARE 資格。
- 如果您已經不再符合該資格, 您必須在 30 天內通知 The Gas Company。
- 您有可能被要求提供符合 CARE 資格的證明文件。

您可能符合條件的優惠計劃和服務:

- **DAP (直接協助計劃):** 一項低收入能源效率計劃, 提供免費的節能住宅改進, 如屋頂絕緣隔熱、房門天氣封條、堵縫和次要的房屋維修。更多訊息, 請致電 1-800-427-1429。
- **Medical Baseline (醫療基線計劃):** 一定醫療狀況的客戶, 較多的瓦斯使用額度, 只需付較低的費率。若需更多訊息請致電 1-800-427-1429。
- **LIHEAP (低收入家庭能源協助計劃):** 提供帳單付費協助、緊急帳單協助和增強禦寒性能服務。請致電 California Department of Community Services and Development (加州社區服務與發展部) 1-866-675-6623。
- **California Lifeline (ULTS) (加州的普濟電話服務計劃):** 提供電話費優惠給類似 CARE 收入標準的低收入消費者。若需更多訊息, 請聯繫您的電話服務公司。

若需更多關於 CARE 計劃的諮詢, 請致電 THE GAS COMPANY:

英語: 1-800-427-2200
韓語: 1-800-427-0471

國語: 1-800-427-1429
粵語: 1-800-427-1420

西班牙語: 1-800-342-4545
越南語: 1-800-427-0478

聽覺障礙專線 (TDD/TTY): 1-800-252-0259 (僅提供英語和西班牙語服務)



CARE 20% 費率折扣申請表

(請用深色筆以正楷填寫清晰以確保適當受理)

Form 6491-B (06/09) CH

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

帳戶號碼:

日期: 06/01/2009

客戶姓名:

地址:

1 您家庭中的總人數 (包括您本人, 其他成年人和兒童):

住宅電話 #: - -

2A 所接受的政府協助計劃福利:
請把您或您家人所接受福利的計劃前塗黑(●), 然後略過 **2B** 直接到 **3**。

- Medi-Cal (加州醫療輔助計劃): 低於 65 歲
- Medi-Cal (加州醫療輔助計劃): 65 或更大年齡
- WIC (婦女, 嬰兒和兒童營養輔助計劃)
- Healthy Families Categories A&B (健康家庭低費兒童醫療健保計劃類別 A 及 B)
- Food Stamps (食物券)
- TANF (AFDC) (貧困家庭臨時現金資助計劃)
- LIHEAP (低收入家庭能源協助計劃)

或

如果以上都不是, 請填寫下一個部分 **2B**。

2B 家庭收入: 請跳過這部分內容如果您已經填寫了 **2A** 部分。

第一部分: 如果您沒有參加以上任何計劃, 請把您家庭收入所有來源前面的圓圈塗黑(●), 並在下方提供的空間內提供您的家庭收入總額:

- | | | |
|---|---------------------------------|---|
| <input type="radio"/> 社會安全福利金 (Social Security) | <input type="radio"/> 工資或薪金 | <input type="radio"/> 法律賠償 |
| <input type="radio"/> 退休金 | <input type="radio"/> 失業救濟金 | <input type="radio"/> 保險賠償 |
| <input type="radio"/> SSI, SSP, SSDI (社會安全補助金) | <input type="radio"/> 殘疾津貼 | <input type="radio"/> 配偶支付的贍養費 |
| 從以下項目獲取的利息或紅利: | <input type="radio"/> 勞工補償 | <input type="radio"/> 子女贍養費 |
| <input type="radio"/> 儲蓄賬戶, 退休金 | <input type="radio"/> 獎學金, 助學金, | <input type="radio"/> 現金或其它收入 |
| <input type="radio"/> 股票或債券 | 或其它用于支付 | <input type="radio"/> 租金或權利金收入 |
| <input type="radio"/> 退休賬戶 | 生活費用的助學津貼 | <input type="radio"/> 自由業收入 (IRS 1040 表格, |
| | | Schedule C 表格, 第 29 行) |

第二部分: 請按照您的稅前家庭年收入, 把適當項目的圓圈塗黑(●)

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

如果多於 \$58,000, 請在此處填寫金額: \$, .00 每年

3 聲明: 請您閱讀並簽字。

我願意證明上述申請資料正確屬實。若需要我也同意提供文件證明符合 CARE 的資格。我同意若我不再符合條件時, 即通知 The Gas Company。我瞭解若不合格接受折扣, 我可能須退還我之前所接受的折扣。我瞭解 The Gas Company 可將有關我的資料提供給其他的公用事業公司和組織團體以協助我加入他們的協助計劃。

簽名: X

日期:



캘리포니아 에너지 대체 요금 신청서

The Gas CompanySM의 캘리포니아 에너지 대체 요금(CARE) 프로그램은 적격 가구의 월별 가스 요금에 대해 20% 할인을 제공합니다. 자격을 갖추고 또한 가스 서비스를 새로 시작한 후 90일 내에 승인을 받은 사람은 가스 개설료에 대해 \$15 할인을 받습니다.

자격이 있는지 보시려면 아래에 제시된 요건을 검토하십시오. 신청서를 작성하여 제공된 봉투에 넣어 제출하십시오. 귀하의 작성되고 서명된 신청서를 The Gas Company에서 승인하면 할인이 적용될 것입니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:
귀하나 기타 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:
Medi-Cal
Food Stamps (푸드 스탬프)
TANF(AFDC)
Women, Infants & Children (WIC, 여성, 유아 및 아동)
Healthy Families A&B (건강한 가족 유형 A 및 B)
LIHEAP

또는

최대 가구 소득: (2009. 6. 1부터 2010. 5. 31까지 유효)	
가구의 식구 수	총 연간 소득
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
추가되는 식구 1인당 추가액	\$7,400

참여 조건

- 가스 청구서는 귀하의 이름으로 되어 있어야 하며 주소는 귀하의 집 주소이어야 합니다.
- 배우자 이외에 다른 사람이 소득세 보고서에서 귀하를 부양가족으로 청구하지 않아야 합니다.
- 요청할 경우 CARE 수혜 자격을 재증명해야 합니다.
- 더 이상 수혜 자격이 없는 경우 30일 이내에 The Gas Company에 통보해야 합니다.
- CARE에 대한 수혜자격을 입증하도록 요청 받을 수 있습니다.

수혜 대상이 가능한 기타 프로그램과 서비스:

- **DAP** - 저소득 에너지 효율 프로그램인 DAP(직접 보조 프로그램)는 천장 단열, 문 통풍 마개 처리, 코킹 및 경미한 주택 수리와 같은 에너지 절약 주택 개량공사를 무료로 제공합니다. 자세한 내용은 1-800-427-0471 번으로 문의하십시오.
- **Medical Baseline (의료 저율요금)** - 특정한 의학적 상태에 처한 고객들에게 저렴한 요금으로 추가 할당량의 가스를 제공합니다. 자세한 내용은 1-800-427-0471 번으로 문의하십시오.
- **LIHEAP** - 저소득 주택 에너지 지원 프로그램인 LIHEAP는 청구금액 지원, 긴급 요금 지원 및 내후 단열 서비스를 제공합니다. 1-866-675-6623 번의 캘리포니아 지역사회 서비스 개발부로 문의하십시오.
- **California Lifeline (ULTS, 캘리포니아 라이프라인)** - CARE와 유사한 소득 기준을 충족시키는 고객들을 위한 할인 전화 이용. 자세한 내용은 현지의 전화회사에 문의하십시오.

CARE에 대한 사항은 아래의 The Gas Company 번호로 문의하십시오:

영어: 1-800-427-2200

북경어: 1-800-427-1429

스페인어: 1-800-342-4545

한국어: 1-800-427-0471

광동어: 1-800-427-1420

월남어: 1-800-427-0478

청각 장애자(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)



CARE 20% 요금 할인 신청서

(정확히 처리되도록 하기 위해 진한 펜을 사용하여 분명히 인쇄체로 기입)

Form 6491-B (06/09) KO

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

구좌 번호:

날짜: 06/01/2009

고객 이름:

주소:

1 귀 가구의 총 식구 수 (귀하, 다른 성인 및 어린이 포함):

주택 전화번호: - -

2A 받는 공공 지원 프로그램 혜택:

귀하나 식구 중에서 혜택을 받는 프로그램에 대해서는 동그라미(●) 안을 채우고 **2B** 번을 건너뛰어 직접 **3** 번으로 가십시오.

- Medi-Cal: 65 세 미만
- Food Stamps
- Healthy Families A&B
- WIC
- Medi-Cal: 65 세 이상
- TANF (AFDC)
- LIHEAP

위의 프로그램 중 어느 것도 해당되지 않으면, 다음의 **2B** 번을 작성하십시오.

가구 소득: **2A** 번을 작성한 경우 건너뛰십시오.

2B 1 부: 위에 나열된 어느 프로그램에도 참여하지 않으시는 경우, 귀 가구의 모든 소득원에 대해 동그라미(●) 안을 채우고 아래에 있는 공란에 총 가구 소득을 기입하십시오:

- | | | |
|--------------------------------------|---------------------------------|-------------------------------------|
| <input type="radio"/> 사회보장금 | <input type="radio"/> 임금 또는 봉급 | <input type="radio"/> 법적 타협금 |
| <input type="radio"/> 연금 | <input type="radio"/> 실업 혜택 | <input type="radio"/> 보험 타협금 |
| <input type="radio"/> SSI, SSP, SSDI | <input type="radio"/> 장애 지원금 | <input type="radio"/> 배우자 생활비 |
| 다음 사항으로부터의 이자나 배당금: | <input type="radio"/> 산재보상금 | <input type="radio"/> 자녀 부양비 |
| <input type="radio"/> 예금 구좌, 연금 | <input type="radio"/> 장학금, 보조금, | <input type="radio"/> 현금 및/또는 기타 소득 |
| <input type="radio"/> 주식이나 채권 또는 | 또는 다음 사항을 위해 | <input type="radio"/> 임대료나 로열티 소득 |
| <input type="radio"/> 은퇴 구좌 | 사용된 기타 보조금 생활비 | <input type="radio"/> 자영업 수익 |
| | | (IRS 양식 1040, 스케줄 C, 29 행) |

2 부: 귀 가구의 공제전 연간 소득 범위에 해당되는 항목의 동그라미(●) 안을 채우십시오.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000

\$58,000 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 \$, .00

3 진술: 아래 사항을 읽고 서명하십시오:

본 신청서에서 제시한 정보가 정확한 사실임을 진술합니다. 본인은 요청 받을 경우 CARE 수혜 자격 증거자료를 제출하기로 동의하였습니다. 본인이 할인을 받을 자격이 더 이상 없게 될 경우 The Gas Company 에 통보함에 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수 있다는 것을 본인은 이해합니다. The Gas Company 에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에 등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: X

날짜:



Sempra Energy utility

Form 6491-B (06/09) VI

ĐƠN XIN GIẢM GIÁ

ĐƠN XIN HƯỞNG MỨC GIÁ NĂNG LƯỢNG THAY THẾ CỦA CALIFORNIA

Chương Trình Mức Giá Năng Lượng Thay Thế của California (California Alternate Rates for Energy hay CARE) của The Gas CompanySM giảm giá 20% trên biên nhận gas hàng tháng cho các hộ gia đình hội đủ điều kiện. Những người nào hội đủ điều kiện và được chấp thuận trong vòng 90 ngày kể từ khi bắt đầu dịch vụ gas mới cũng sẽ được giảm giá \$15 trên Chi Phí Nhận Dịch Vụ (Service Establishment Charge).

Để biết quý vị có hội đủ điều kiện hay không, xin xem kỹ những yêu cầu nêu ra sau đây. Xin điền đầy đủ vào đơn và gửi trả lại bằng phong bì được cung cấp sẵn. Sẽ áp dụng giảm giá khi đơn xin đã điền đầy đủ và ký tên của quý vị được The Gas Company chấp thuận.

CÓ 2 CÁCH ĐỂ HỘI ĐỦ ĐIỀU KIỆN ĐƯỢC GIẢM GIÁ THEO CHƯƠNG TRÌNH CARE:

CÁC CHƯƠNG TRÌNH TRỢ GIÚP CÔNG CỘNG:
Nếu quý vị hay người nào khác trong hộ gia đình của quý vị nhận trợ cấp từ bất cứ chương trình nào sau đây:
Medi-Cal
Phiếu Thực Phẩm (Food Stamps)
TANF(AFDC)
Phụ Nữ, Trẻ Sơ Sinh & Trẻ Em (Women, Infants & Children hay WIC)
Gia Đình Khỏe Mạnh Loại A&B (Healthy Families Categories A&B)
LIHEAP

HOẶC

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH: (có hiệu lực từ ngày 1 tháng Sáu, 2009 đến 31 tháng Năm, 2010)	
Số Người trong Hộ Gia Đình	Tổng Lợi Tức Hàng Năm
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Mỗi người Thêm vào trong Hộ Gia Đình, được cộng thêm	\$7,400

ĐIỀU KIỆN ĐỂ THAM GIA

- Quý vị phải là người đứng tên trong biên nhận gas và địa chỉ phải là địa chỉ chính của quý vị.
- Quý vị không được là người tùy thuộc trong hồ sơ khai thuế của người khác ngoại trừ người phối ngẫu của mình.
- Quý vị phải tái xác nhận sự hội đủ điều kiện của mình theo chương trình CARE khi được yêu cầu
- Quý vị phải thông báo cho The Gas Company trong vòng 30 ngày nếu quý vị không còn hội đủ điều kiện nữa.
- Quý vị có thể được yêu cầu thẩm tra tình trạng hội đủ điều kiện của mình cho chương trình CARE.

CÁC CHƯƠNG TRÌNH VÀ DỊCH VỤ KHÁC MÀ QUÝ VỊ CÓ THỂ HỘI ĐỦ ĐIỀU KIỆN:

- **DAP** - Direct Assistance Program, là chương trình tiết kiệm hiệu quả năng lượng cho người có lợi tức thấp giúp sửa chữa miễn phí trong nhà để tiết kiệm năng lượng như gắn cách nhiệt trần nhà, bịt khe cửa, trét chỗ hở và các sửa chữa nhỏ trong nhà. Để biết thêm thông tin, xin gọi 1-800-427-0478.
- **Medical Baseline (Chương Trình Y Tế Cơ Bản)** – Cung cấp thêm tiêu chuẩn gas được dùng ở mức giá thấp hơn cho các khách hàng đang có bệnh trạng nào đó. Để biết thêm thông tin, xin gọi 1-800-427-0478.
- **LIHEAP** - Low Income Home Energy Assistance Program (Chương Trình Trợ Giúp Năng Lượng Tại Gia cho Người Có Lợi Tức Thấp) giúp trả biên nhận, trợ giúp biên nhận khẩn cấp và các dịch vụ thích nghi với thời tiết. Xin gọi California Department of Community Services and Development (Sở Dịch Vụ Cộng Đồng và Phát Triển California) tại số 1-866-675-6623.
- **California Lifeline (ULTS)** - Giảm giá điện thoại cho các khách hàng hội đủ điều kiện theo hướng dẫn về lợi tức tương tự như chương trình CARE. Để biết thêm thông tin, xin liên lạc với nhà cung cấp dịch vụ điện thoại địa phương của quý vị.

ĐỂ BIẾT THÊM THÔNG TIN VỀ CHƯƠNG TRÌNH CARE, XIN GỌI CHO THE GAS COMPANY TẠI:

Tiếng Anh: 1-800-427-2200

Quan Thoại: 1-800-427-1429

Tây Ban Nha: 1-800-342-4545

Đại Hàn: 1-800-427-0471

Quảng Đông: 1-800-427-1420

Tiếng Việt: 1-800-427-0478

Số Máy dành cho Người Khiếm Thính (TDD/TYY): 1-800-252-0259 (chỉ có sẵn bằng tiếng Anh và tiếng Tây Ban Nha)



Đơn Xin Giảm Giá 20% Theo Chương Trình CARE

(Xin dùng mực đậm và viết bằng chữ in để đảm bảo xét duyệt chính xác)

Form 6491-B (06/09) VI

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



Số Trương Mục:

Ngày: 06/01/2009

Tên Khách Hàng:

Địa chỉ:

1 Tổng số người trong hộ gia đình của quý vị (bao gồm quý vị, người lớn khác, và trẻ em):

Điện Thoại Nhà #: - -

2A Các Trợ Cấp từ các Chương Trình Trợ Giúp Công Cộng (Public Assistance Programs):

Hãy bôi đen vào vòng tròn (●) cho bất cứ chương trình nào mà quý vị hay ai đó trong gia đình của quý vị nhận trợ cấp, sau đó BỎ QUA phần **2B** và điền vào phần **3**.

- Medi-Cal: Dưới 65 tuổi
- Food Stamps
- Healthy Families A&B
- WIC
- Medi-Cal: 65 tuổi trở lên
- TANF (AFDC)
- LIHEAP

HOẶC Nếu KHÔNG có mục nào ở trên, hãy điền vào Phần **2B**.

2B Lợi Tức Hộ Gia Đình: Bỏ qua phần này nếu quý vị đã điền vào Phần **2A**.

Phần 1: Nếu quý vị không tham gia vào bất cứ chương trình nào được liệt kê ở trên, xin bôi đen vào vòng tròn (●) cho tất cả các nguồn lợi tức của hộ gia đình quý vị, và cung cấp tổng lợi tức gia đình của quý vị vào các khoảng trống bên dưới:

- An Sinh Xã Hội
- Lương tuần hay lương tháng
- Bồi Thường theo Pháp Luật
- Hưu Bổng
- Trợ Cấp Thất Nghiệp
- Bồi Thường Bảo Hiểm
- SSI, SSP, SSDI
- Trợ Cấp Tàn Phế
- Tiền Nuôi Người Phổi Ngẫu
- Lợi Tức hay Cổ Tức từ:
- Bồi Thường Lao Động
- Tiền Nuôi Con Cái
- Trương Mục Tiết Kiệm, Hưu bổng
- Học Bổng, Tài Trợ hay Trợ Giúp Khác Dùng để trang
- Lợi Tức Tiền Mặt và/hoặc lợi tức khác
- Cổ Phiếu hay Trái Phiếu, hoặc
- trả Chi Phí Sinh Hoạt
- Lợi Tức Khi Cho Thuê hay Tiền Bản Quyền
- Trương Mục Hưu Trí
- Lợi nhuận khi Làm Việc Tự Do(Mẫu đơn 1040, Bản Kê C, dòng 29 của IRS)

Phần 2: Hãy bôi đen vào vòng tròn (●) mức lợi tức hàng năm của hộ gia đình trước khi khấu trừ.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000
- Nếu nhiều hơn \$58,000, xin điền tổng số vào đây: \$, .00 mỗi năm

3 Lời Khai: Xin đọc và ký bên dưới.

Tôi xin khai rõ rằng thông tin mà tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý sẽ cung cấp bằng chứng về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý thông báo cho The Gas Company biết nếu tôi không còn hội đủ điều kiện để nhận giảm giá nữa. Tôi hiểu rằng nếu tôi được giảm giá khi không hội đủ điều kiện, tôi có thể được yêu cầu phải trả lại khoản giảm giá mà tôi đã nhận. Tôi hiểu rằng The Gas Company có thể chia sẻ thông tin của tôi với các hãng tiện ích khác hoặc các đại lý để ghi danh tôi vào các chương trình trợ giúp của họ.

Chữ ký: X

Ngày:

**طلب تخفيض
%20**



طلب للحصول على أسعار بديلة للطاقة بولاية كاليفورنيا

يوفر برنامج الأسعار البديلة للطاقة بولاية كاليفورنيا (California Alternate Rates for Energy, CARE) من شركة The Gas Company تخفيضاً مقداره 20% على فاتورة الغاز الشهرية للعائلات المؤهلة. كما سيتلقى أولئك المؤهلون والذين تمت الموافقة عليهم خلال 90 يوماً من بدء خدمة غاز جديدة تخفيضاً قدره 15 دولاراً من تكلفة تأسيس الخدمة. يرجى ملئ الاستمارة التالية وإعادتها خلال 90 يوماً.

لكي تتحقق من تأهلك، يرجى مراجعة المتطلبات المدرجة أدناه. يرجى ملئ الطلب وإعادته في الطرف المرفق. سيتم حسم التخفيض حال موافقة SM The Gas Company على طلبك المستكمل والموقع.

هناك طريقتان للتأهل لتخفيض CARE:

برامج المساعدة الحكومية:	الحد الأعلى لدخل العائلة:
إذا كنت أنت أو أي من أفراد أسرته تتلقون معونات من أي من البرامج التالية:	(ساري المفعول من 1 يونيو/حزيران، 2009 حتى 31 مايو/أيار، 2010)
Medi-Cal	الدخل السنوي الإجمالي
Food Stamps	عدد الأشخاص في العائلة
TANF (AFDC)	2-1
Woman, Infant & Children (WIC)	3
Healthy Families Categories A&B	4
LIHEAP	5
	6
	لكل شخص إضافي في العائلة، أضيف
	30500 دولار
	35800 دولار
	43200 دولار
	50600 دولار
	58000 دولار
	7400 دولار

شروط الاشتراك

- يجب أن تكون فاتورة الغاز باسمك وأن يكون العنوان هو عنوانك الرئيسي.
- يجب ألا تكون مدرجاً كشخص تابع على استمارة الضريبة لشخص آخر غير زوجتك والعكس صحيح.
- يجب أن تعيد تأكيد المعلومات على طلبك عند الطلب.
- عليك إبلاغ The Gas Company خلال 30 يوماً من عدم تأهلك.
- قد يُطلب إليك إثبات تأهلك لـ CARE.

قد تتأهل لبرامج أو خدمات أخرى:

- **Direct Assistance Program – DAP**، برنامج فعالية الطاقة لذوي الدخل المحدود. يقدم تحسينات منزلية مجانية لتوفير الطاقة مثل عزل السقف، وضع شرائط عزل حول الأبواب، إملء الفراغات وإصلاحات ثانوية للمنزل. لمزيد من المعلومات، يرجى الاتصال بـ 1-888-427-1345.
- **Medical Baseline** – يوفر حصة إضافية من الغاز بسعر أرخص للعملاء ذو الاحتياجات الطبية الخاصة. لمزيد من المعلومات، اتصل بالرقم 1-888-427-1345.
- **Low Income Home Energy Assistance Program – LIHEAP**، ويقدم مساعدة في دفع الفاتورة وخدمات مقاومة العوامل الجوية. اتصل بـ California Department of Community Services and Development على الرقم: 1-866-675-6623.
- **California Lifeline (ULTS)** – خدمة هاتفية مخفضة للعملاء الذين يحققون مستويات دخل مماثلة لـ CARE. لمزيد من المعلومات، اتصل بالشركة المزودة للخدمات الهاتفية لمنطقتك.

لمزيد من المعلومات حول CARE، اتصل بـ The GAS COMPANY على الرقم: 1-888-427-1345



Sempra Energy utility

Form 6491-B (05/09) ARA

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

طلب تخفيض 20% الخاص ببرنامج CARE
(يرجى استخدام حبر غامق والكتابة بوضوح كي تتم دراسة الطلب بشكل جيد)

اسم العميل:

العنوان:

المحل/ الشقة رقم:

المدينة:

الرمز البريدي:

9B :Source Code

رقم الحساب:

عدد أفراد العائلة (بمن فيهم أنت، والبالغين الآخرين والأطفال):

1

رقم الهاتف:

تلقى خدمات برامج مساعدة حكومية:

إذا كنت أنت أو شخص آخر في عائلتك تتلقون خدمات من أي من البرامج المدرجة أدناه، يرجى إكمال الدائرة (●)، ثم الانتقال إلى **2B** ثم مباشرة إلى **3**.

2A

WIC ○ Healthy Families A&B ○ Food Stamps ○ Medi-Cal: تحت سن 65
LIHEAP TANF (AFDC) ○ Medi-Cal: 65 سنة أو أكبر ○

أو

إذا لم ينطبق أي مما سبق عليك، يرجى إكمال الجزء **2B**.

دخل الأسرة: يرجى إهماله إذا أكملت الجزء **2A**

الجزء **1**: إذا لم تكن مشتركاً في أي من البرنامج المدرجة أعلاه، يرجى إكمال الدائرة (●) لكافة مصادر الدخل في عائلتك ثم ضع دخل الأسرة الإجمالي في الفراغات المدرجة أدناه:

2B

○ تسويات قانونية	○ المرتبات والأجور	○ Social Security
○ تسويات قضايا تأمين	○ تعويضات العاطلين عن العمل	○ تعويضات
○ نفقة زوجية	○ تعويضات عجز (إعاقة)	○ SSI, SSP, SSDI
○ نفقة أطفال	○ تعويضات العاملين	○ فوائد أو أرباح من:
○ نقد و/أو مصدر دخل آخر	○ منح، هبات أو مساعدات	○ حسابات ادخار، تعويضات
○ إيجار عقارات أو حقوق ملكية	○ أخرى تستخدم للمساعدة	○ أسهم أو سندات
○ أرباح من عمل حر	○ في النفقات المعيشية	○ حسابات تقاعد

(IRS Form 1040, Schedule C, line 29)

الجزء **2**: يرجى إكمال الدائرة (●) حسب دخل عائلتك الإجمالي في السنة قبل الخصومات.

○ 0-30500 دولار ○ 30501-35800 دولار ○ 35801-43200 دولار ○ 43201-50600 دولار ○ 50601-58000 دولار

○ إذا زاد عن الدخل عن 58000 دولار ضع الرقم هنا: 00.00 \$ في السنة

تصريح: يرجى قراءة ما يلي والتوقيع أدناه.

3

أصرح بأن المعلومات التي أوردتها في هذا الطلب هي صحيحة وحقيقية. وأوافق على تقديم إثبات على أهليتي لبرنامج CARE في حال طلب مني. كما أوافق على إبلاغ The Gas Company في حال لم أعد مؤهلاً لاستلام التخفيض. إنني أعرف أنه في حال استلامي التخفيض دون أن أكون مؤهلاً، فقد يُطلب إلي دفع التخفيضات التي استلمتها. كما أعرف بأن The Gas Company قد تقدم معلوماتي إلى شركات خدمات أو مكاتب أخرى لإدراج برامج المساعدة الخاصة بهم.

التاريخ:

التوقيع: X



A Sempra Energy utility

**20% CARE
ՉԵՂՉԻ ԴԻՄՈՒՄ**

ԿԱԼԻՖՈՐՆԻԱՅԻ ԱՅԼԸՆՏՐԱՆՔԱՅԻՆ ԳՆԵՐԸ ԷՆԵՐԳԻԱՅԻ ԴԻՄՈՒՄԻ ՀԱՄԱՐ

The Gas Company-ի California Alternate Rates for Energy (CARE) (Կալիֆորնիայի Այլընտրանքային Գները Էներգիայի համար) պայմանուևակ ընտանիքներին ծրագիրը մատակարարում է ամսական 20% գեղջ գազի հաշվի համար: Նրանք, ովքեր որակավորված են և վավերացված՝ գազի նոր ծառայությունը սկսելուց 90 օրվա ընթացքում, կստանան նաև \$15 գեղջ Ծառայության Հաստատման Ծախքի համար: Խնդրվում է լրացնել այս ձևը և վերադարձնել 90 օրվա ընթացքում:

Որպեսզի իմանաք, թե դուք արդյոք որակավորված եք, ստուգեք ստորև նշված պահանջները: Խնդրվում է լրացնել դիմումը և վերադարձնել մատակարարված ծրագրով: Չեղչը կկիրառվի, երբ որ ձեր լրացված և ստորագրված դիմումի ձևը հաստատվի The Gas CompanySM-ի կողմից:

ԵՐԿՈՒ ՃԱՆԱՊԱՐՅ ԿԱ CARE ՉԵՂՉԸ ՍՏԱՆԱԼՈՒ ՀԱՄԱՐ՝

ՀԱՄԱՐԱԿԱԿԱՆ ՕԳՆՈՒԹՅԱՆ ԾՐԱԳՐԵՐԸ՝
Եթե դուք կամ ձեր ընտանիքից ուրիշ անդամ օգտվում եք հետևյալ ծրագրերից որևէ մեկից՝
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infant & Children (WIC)
Healthy Families Categories A&B
LIHEAP

ԿԱՍ

ԱՌԱՎԵԼԱԳՈՒՅՆ ԸՆՏԱՆԵԿԱՆ ԵԿԱՄՈՒՄ՝ (ուժի մեջ է հունիսի 1, 2009թ. մինչև մայիսի 31, 2010թ.)	
Ընտանիքի անդամների թիվը	Ընդհ. տարեկան եկամուտը
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Ամեն մի լրացուցիչ ընտանիքի անդամի համար ավելացրեք	\$7,400

ՄԱՍՆԱԿՑՈՒԹՅԱՆ ՊԱՅՄԱՆՆԵՐ

- Գազի հաշիվը պետք է ձեր անունով լինի և հասցեն պետք է ձեր հիմնական հասցեն լինի:
- Չպետք է կախյալ համարվեք, բացի ձեր ամուսնուց, որևէ այլ անձի եկամտային հարկի հաշվետվության մեջ:
- Դուք պետք է կրկին վավերացնեք ձեր դիմումը, երբ որ պահանջվի:
- Դուք պետք է հայտնեք The Gas Company-ին 30 օրվա ընթացքում, եթե այլևս որակավորված չեք:
- Ձեզանից կարող է խնդրեն ստուգել ձեր որակավորումը CARE-ի համար:

ԱՅԼ ԾՐԱԳՐԵՐ ԿԱՍ ԾԱՌԱՅՈՒԹՅՈՒՆՆԵՐ, ՈՐՈՆՑ ԴՈՒՔ ԿԱՐՈՂ Ե ՈՐԱԿԱՎՈՐՎԱԾ ԼԻՆԵՐ՝

- **DAP** - Direct Assistance Program, ցածր եկամտի Էներգիայի արդյունավետության ծրագիր է, որն առաջարկում է անվճար Էներգիա խնայող տնային բարելավումներ, ինչպիսիք են առաստաղի մեկուսացում, դռան եղանակային մերկացում, գաճում և մանր տնային վերանորոգումներ: Լրացուցիչ տեղեկությունների համար խնդրվում է զանգահարել 1-888-427-1345 հեռախոսի համարով:
- **Medical Baseline** - Մատակարարում է լրացուցիչ գազի թույլտվություն ավելի ցածր գնով որոշակի առողջական վիճակ ունեցող հաճախորդներին: Լրացուցիչ տեղեկությունների համար զանգահարեք 1-888-427-1345 հեռախոսի համարով:
- **LIHEAP** - Low Income Home Energy Assistance Program մատակարարում է հաշիվների վճարման օգնություն, վթարների օգնություն և եղանակի հետ կապված ծառայություններ: Չանգահարեք California Department of Community Services and Development 1-866-675-6623 հեռախոսի համարով:
- **California Lifeline (ULTS)** - Չեղչով հեռախոսային մուտք՝ CARE-ի նման եկամտային ցուցմունքներին որակավորված հաճախորդների համար: Լրացուցիչ տեղեկությունների համար դիմեք ձեր տեղական հեռախոսային ծառայությունների մատակարարողին:

**CARE ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐԻ ՀԱՄԱՐ, ՉԱՆԳԱՀԱՐԵՔ THE GAS COMPANY-ին՝
1-888-427-1345**



تقاضا نامه نرخهای جایگزین برای انرژی در کالیفرنیا

برنامه نرخهای جایگزین انرژی شرکت گاز برای کالیفرنیا (Alternate Rates for Energy-CARE) برای خانواده های واجد شرایط 20% تخفیف در قبض ماهیانه گاز قابل میشود. آنهایی که واجد شرایط بوده و صرف 90 روز از شروع خدمات جدید گاز مورد تایید قرار گیرند 15 دلار تخفیف از هزینه راه اندازی خدمت خواهند گرفت. لطفا این فرم را کامل کرده و ظرف 90 روز بفرستید.

برای آگاهی از احراز صلاحیت خود شرایط زیر را ملاحظه فرمایید. لطفا این تقاضا نامه را کامل کرده و در پاکت نامه که در اختیاران گذاشته شده بفرستید. تخفیف هنگامی به شما داده میشود که شرکت گاز (The Gas CompanySM) تقاضانامه کامل و امضا شده شما را تایید کند.

دو راه برای احراز صلاحیت شما برای تخفیف CARE وجود دارد:

حد اکثر درآمد خانواده:	
موثر از تاریخ اول جونیو 2009 تا 31 مه 2010	
تعداد افراد در خانواده	مجموع درآمد سالانه
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
برای هر فرد اضافه بیافزاید	\$7,400

یا

برنامه های امداد عمومی:	
اگر شما و یا شخص دیگری در منزل شما از یکی از برنامه های زیرفایده ای دریافت میکند:	
Medi-Cal	مدیکال
Food Stamps	کوپن غذا
TANF(AFDC)	کمک موقت به خانواده های نیازمند
Women, Infant & Children (WIC)	زنان، نوزادان و کودکان
Healthy Families Categories A&B	خانواده های تندرست
LIHEAP	کمک برای انرژی

شرایط برای شرکت

- قبض گاز باید به نام شما باشد و آدرس باید آدرس اصلی شما و به نام شما باشد.
- کسی به غیر از همسرتان شما را به عنوان وابسته در مالیات خویش درج نکرده باشد.
- هنگامی که از شما تقاضا گردد شما باید تقاضانامه خود را مجدداً تایید نمایید.
- اگر شما دیگر واجد شرایط نیستید میباید شرکت گاز را (The Gas Company) ظرف 30 روز مطلع سازید.
- ممکن است از شما خواسته شود تا صلاحیت خود را برای CARE نشان دهید.

برنامه ها و خدمات دیگر که شما ممکن است برای آنها واجد شرایط باشید:

- **DAP**-برنامه کمک مستقیم، یک برنامه بهینه سازی انرژی، به شما برای بهینه سازی استفاده از انرژی به صورت رایگان کمک میکند. این کمکها شامل عایق کردن سقف، روزنه گیری درب، درزگیری و تعمیرات جزئی منزل میشوند. برای اطلاعات بیشتر با شماره زیر تماس بگیرید: 1-888-427-1345
- **Medical Baseline** - این برنامه مقادیر بیشتری گاز را به قیمت پایین برای مشتریان با برخی شرایط پزشکی فراهم میکند. برای اطلاعات بیشتر با شماره زیر تماس بگیرید: 1-888-427-1345
- **LIHEAP**- برنامه کمک انرژی برای خانواده های کم در آمد خدمات کمک پرداخت قبض، کمک اضطراری برای پرداخت قبض، متناسب کردن با آب و هوا را فراهم میکند. به سازمان خدمات اجتماعی کالیفرنیا California Department of Community Services با شماره 1-866-675-6623 تماس بگیرید.
- **California Lifeline (ULTS)** - خدمات دسترسی تلفنی با تخفیف برای مشتریانی که شرایط درآمدی مشابهی به CARE دارند. برای اطلاعات بیشتر با فراهم کننده محلی تلفن خود تماس بگیرید.

برای اطلاعات درباره CARE با شرکت گاز با شماره های زیر تماس بگیرید: 1-888-427-1345



تقاضا نامه نرخ تخفیف مراقبت (CARE) 20%

(لطفاً از جوهر تیره استفاده کرده و واضح چاپ کنید تا از رسیدگی مناسب اطمینان حاصل شود)

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



نام و نام خانوادگی مشتری:

آدرس: #آپارتمان / محوطه:

شهر: کد پستی:

شماره حساب: Source Code: 9B

1 تعداد افراد در خانوار شما (شامل شما، افراد بالغ دیگر، و کودکان):

شماره تلفن منزل #: - -

مزایای برنامه کمکهای دولتی دریافت شد

اگر شما یا یکی از اعضای خانواده شما از یکی از برنامه های زیر استفاده میکند، لطفاً داخل دایره را پر کنید (●) و سپس قسمت 2B را نادیده گرفته و مستقیماً به قسمت 3 بروید.

- مدیکال: زیر 65 سال
 مدیکال: 65 و بالاتر
 کوپن غذا
 خانواده های تندرست A و B و Healthy Families
 WIC
 TANF (AFDC)
 LIHEAP

اگر هیچ یک از برنامه های بالا برای شما نیست پس قسمت 2B را کامل کنید.

2A

یا

در آمدخانوار: اگر قسمت 2A را کامل کردید این قسمت را پر نکنید.
بخش 1: اگر شما در هیچ یک از برنامه های فوق شرکت نمیکنید، لطفاً داخل دایره را (●) که به تمام منابع درآمد خانوار شما مربوط میباشد را علامت زده و مجموع درآمد خانه را در مکان مشخص شده زیر درج کنید:

2B

- | | | |
|---|--|--|
| <input type="radio"/> سوشل سکيوريتي | <input type="radio"/> دستمزد با حقوق | <input type="radio"/> مصالحه حقوقی |
| <input type="radio"/> حقوق بازنشستگي | <input type="radio"/> مزایای از کار افتادگی | <input type="radio"/> مصالحه های بیمه |
| <input type="radio"/> SSI, SSP, SSD | <input type="radio"/> پرداختی های معلولیت | <input type="radio"/> حمایت از همسر |
| <input type="radio"/> بهره یا سود از: | <input type="radio"/> غرامت کارگری | <input type="radio"/> حضانت کودک |
| <input type="radio"/> حسابهای پس انداز و حقوق بازنشستگي | <input type="radio"/> بورس، گرانت یا هر گونه کمک | <input type="radio"/> پول نقد و/یا درآمد دیگر |
| <input type="radio"/> سهام یا اوراق بهادار | <input type="radio"/> برای هزینه زندگی | <input type="radio"/> درآمد از کرایه دادن یا از حق امتیاز |
| <input type="radio"/> حسابهای بازنشستگي | <input type="radio"/> سود از کار آزاد | <input type="radio"/> (IRS Form 1040, Schedule C, line 29) |

قسمت 2: لطفاً داخل دایره مربوط به حدود درآمد سالانه منزل شما قبل از کسورات علامت (●) بگذارید

- \$0 - \$30,500
 \$30,501 - \$35,800
 \$35,801 - \$43,200
 \$43,201 - \$50,600
 \$50,601 - \$58,000

اگر بیشتر از \$58,000، مبلغ را در این خانه ها بنویسید: \$, , .00 سالانه

اعلامیه: لطفاً بخوانید و امضا کنید.

3

من اعلام میکنم که اطلاعات فراهم شده در این تقاضانامه صحیح و درست است. من موافقت میکنم تا در صورت لزوم گواهی و اجداشراطی CARE را فراهم کنم. من موافقت میکنم تا در صورت صلب شرایط شرکت گاز را (The Gas Company) مطلع کنم. من متوجهم که در صورت دریافت خدمات بدون داشتن شرایط لازم ممکن است وادار به پس دادن تخفیف گردم. من متوجهم که شرکت گاز (The Gas Company) میتواند اطلاعات من را در اختیار نمایندگان سایر خدمات بگذارد تا آنها مرا در برنامه کمک خود ثبت نام کنند.

تاریخ:

امضاء: X



A Sempra Energy utility

**DAIM NTAWV
CARE TXIAV 20%**

DAIM NTAWV RAU CALIFORNIA ALTERNATE RATES FOR ENERGY

The Gas Company txoj kev pab California Alternate Rates for Energy (CARE) txiav tau 20% ntawm qhov nuj nqe them txhua hli rau nqe nkev rau tej tsev neeg uas tsim nyog. Tej tus xoom khuas raug txais es tsis tau txog 90 hnuv twb raug txais lawm thaum qhib nkev tshiab kuj yuav raug txiav \$15 tawm ntawm qhov Service Establishment Charge uas raug them thaum qhib nkev tshiab. Thov ua daim ntawv no kom tiav thiab muaj xa tuaj ua ntej 90 hnuv.

Kom paub seb koj puas yuav tsim nyog raug txais, saib cov kev laij hauv qab no. Thov ua daim ntawv no thiab muab xa rov qab hauv lub hnab xoos ntawv uas muab nrog daim ntawv no. Qhov kev yuav txiav nuj nqes tawm yuav pib thaum The Gas CompanySM tso cai lawm.

MUAJ OB TXOJ KEV YUAV LOS TXAIS TAU QHOV CARE DISCOUNT:

KEV PAB CUAM XOOM QHAUB:
Yog koj lossis lwm tus neeg hauv koj tsev neeg txais kev pab los ntawm cov kev pab cuam no:
Medi-Cal
Nyiaj Muas Noj (Food Stamps)
TANF(AFDC)
Tshev Mis (WIC)
Healthy Families Categories A&B
LIHEAP

LOSSIS

TAG NRHO TSEV NEEG COV NYIAJ KHWV TAU: <i>(pib thaum June 1, 2009 rau May 31, 2010)</i>	
Npaum li cas tus neeg hauv lub tsev	Khwv tau ib xyoos npaum li cas tag nrho ua ke
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Tshaj ib tug neeg ntxiv, ces ntxiv npaum li no	\$7,400

LI CAS THIAJ LI SIV TAU

- Daim nqe nkev yuav tsum ua koj npe thiab qhov chaw nyob yuav tsum yog koj li chaw nyob.
- Koj tsis raug ua dependent hauv lwm tus daim income tax return rhu ntawm koj tus txwj nkawm.
- Koj yuav tsum rov ua daim ntawv no dua yog thaum hais.
- Koj yuav tsum qhia rau The Gas Company ua ntej 30 hnuv yog tias koj tsis tsim nyog raug txais lawm.
- Tej zaum yuav kom koj lees tseeb tias koj yeej tsim nyog raug txais CARE.

LWM YAM KEV PAB CUAM UAS TEJ ZAUM KOJ YUAV TSIM NYOG RAUG TXAIS:

- **DAP** - Direct Assistance Program, ib qho kev pab cuam rau tej tsev uas khwv tau nyiaj xtiag tsawg kom siv dej taws tsawg. Nws muaj kev xab vaj tse kom siv dej taws tsawg xws li insulation rau tej tsw tsev, muab tej kab yas los xiab qhov rooj, muab kuas yas ham tsev thiab khob me ntsis lub tsev. Kom paub ntxiv txog, thov hu rau 1-888-427-1345.
- **Medical Baseline** – Pab kom tau nkev ntxiv thiab nqe nkev tsawg rau tej tus uas muaj tej hom kev mob kev nqeeg. Kom paub ntxiv txog, hu rau 1-888-427-1345.
- **LIHEAP** - Low Income Home Energy Assistance Program pab them me ntsis nuj nqes, pab them tej thaum ti tes thiab kev los xab kom yus lub tsev thev taus hua cuab. Hu rau lub California Department of Community Services and Development ntawm 1-866-675-6623.
- **California Lifeline (ULTS)** – Ib qho kev tauj xov tooj kom pheej yig rau tej tus uas muaj ntsis raws nraim li qhov yuav tsim nyog raug txais CARE. Kom paub ntxiv txog, hu rau koj lub hoob kas tauj xov tooj.

KOM PAUB QHIA TAU TXOG CARE, HU RAU THE GAS COMPANY NTAWM: 1-888-427-1345



DAIM NTAWV CARE TXIAV 20% NTAWM NUJ NQES

(Thov siv tej xim uas tsaus tsaus thiab sau kom mee pem thiaj li txiaiv txim tau thwj)

Form 6491-B (05/09) HMO

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Npe:

Chaw Nyob: Chav/Chav Tsev #:

Zos: Zauv Zip:

Tus Lej Account: Source Code: 9B

1 Tag nrho cov neeg hauv lub tsev (koj tus kheej, lwm cov neeg laus, thiab cov me nyuam):

Xov tooj hauv tsev #: - -

2A **Kev pab cuam xoom qhaub uas nej txais:**
Yog koj lossis lwm tus neeg hauv koj tsev raug txais kev pab cuam ntawm cov kev pab cuam hauv qab no, thov thas lub voj voos (●), ces HLAB them **2B** thiab mus ncaj qha rau them **3**.

LOSSIS

- Medi-Cal: Tsis tau muaj 65 xyoos
- Nyiaj muas noj (Food Stamps)
- Healthy Families A&B
- Tshev Mis (WIC)
- Medi-Cal: 65 lossis laus dua
- TANF (AFDC)
- LIHEAP

Yog TSIS MUAJ tej yam li no li, ces ua them **2B kom tiav.**

2B **Tag nrho ib tse cov nyiaj txiag khwv tau: Hla qho no yog tias koj tau ua them **2A** lawm.**
Ntu 1: Yog koj tsis nyob rau cov kev pab cuam uas muaj li saum ntej no, thov thas lub voj voos (●) rau txhua txoj kev txais tau nyiaj txiag hauv koj lub tsev, thiab qhia tias koj tsev neeg tau nyiaj txiag ib xyoos npaum li cas hauv cov chaw nram qab no:

- Social Security
- Pensions
- SSI, SSP, SSDI
- Paj, Interest los Dividends los ntawm:
 - Savings Accounts, Pensions
 - Stocks lossis Bonds
 - Retirement Accounts
- Nyiaj ua hauj lwm
- Nyiaj Unemployment
- Nyiaj Xiam
- Workers Compensation
- Scholarships, Grants, lossis Lwm Yam Aid Uas Siv rau tej iving Expenses
- Nyiaj Plaub Ntug
- Nyiaj Pav Kas Phais
- Nyiaj Spousal Support
- Nyiaj Child Support
- Nyiaj Ntsuab/lwmyam txaisnyiaj
- Nyiaj Xauj Tsev/Royalty Income
- Nyiaj Self-Employment (IRS Form 1040, Schedule C, line 29)

Ntu 2: Thov thas lub voj voos (●) uas yog koj tsev neeg cov nyiaj txiag txais tau txhua xyoo ua ntej txiaiv se tawm.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000

Yog tias tshaj \$58,000, muab sau rau ntawm no: \$, .00 tauj ib xyoos

3 **Lus Lees:** Thov nyeem thiab xees hauv qab no.

Kuv hais tseeb tias tej yam kuv muab sau rau daim ntawv no muaj tiag thiab thwj. Kuv txaus siab muab pov thawj rau CARE kom paub tias kuv tsim nyog raug txais yog nug kuv. Kuv txaus siab qhia rau The Gas Company yog kuv tsis tsim nyog raug txais qhov kev txo nuj nqes no lawm. Kuv nkag siab tias yog kuv raug txais qhov kev txo nuj nqes no, es kuv yeej tsis tsim nyog raug txais, tej zaum kuv yuav tau rov them cov nqe uas muab txiaiv tawm lawm. Kuv nkag siab tias The Gas Company qhia tau txog kuv tej yam kuv qhia saum no rau lwm lub hoob kas dej taws lossis lwm tus neeg ua hauj lwm rau lawv kom muab tau kuv rau lawv cov kev pab cuam thiab.

Xees Npe: X Hnub:



ក្រដាសដាក់សុំការចុះតម្លៃ ២០ ភាគរយ នៃកម្មវិធីវិយារ (CARE)

ក្រដាសដាក់សុំសំរាប់តម្លៃនានាសំរាប់ម៉ោងពលនៃរដ្ឋកាលីហ្វ័រញ៉ា

កម្មវិធីនៃតម្លៃនានានៃក្រុមហ៊ុន The Gas Company's California Alternate Rates សំរាប់ (CARE) ផ្តល់ជាការចុះតម្លៃ ២០ ភាគរយនៃការចុះតម្លៃចំពោះសំបុត្រទារលុយសំរាប់ ផ្ទះសំបែងណាដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីនេះ ។ លោកអ្នកដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន ហើយត្រូវបានអនុញ្ញាតក្នុងកំឡុង ៤០ ថ្ងៃនៃការចាប់ផ្តើមសេវាកម្ម ហ្គាសថ្មី ក៏នឹងទទួលបានការចុះតម្លៃ ១១៥នៃការស្ថាបនាសេវាកម្មនៃការទារលុយ ។ សូមបំពេញក្រដាសសុំនេះ ហើយផ្ញើមកវិញនៅក្នុងកំឡុងពេល ៤០ ថ្ងៃ។

ដើម្បីរកឃើញថាតើលោកអ្នកមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន ឬទេ សូមស្វែងរកកិច្ចសន្យាបញ្ជាខាងក្រោម ។ សូមបំពេញក្រដាសសុំ ហើយផ្ញើមកវិញ នៅក្នុងរយៈពេលសំបុត្រ ដែលបានផ្តល់ជូនដល់លោកអ្នក ។ ការចុះតម្លៃនឹងអាចយកមកអនុវត្តក្រោយពីលោកអ្នកបានបំពេញរួចហើយ ហើយចុះហត្ថលេខានៅលើក្រដាសសុំ ហើយត្រូវបានអនុញ្ញាត ដោយក្រុមហ៊ុន The Gas CompanySM។

មានមធ្យោបាយពីរ ដើម្បីនឹងមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានសំរាប់ការចុះតម្លៃនៃការថែទាំ :

កម្មវិធីជំនួយសាធារណៈ:
បើលោកអ្នក ឬនរណាម្នាក់ទៀតនៅក្នុងផ្ទះរបស់លោកអ្នក ទទួលបានអត្ថប្រយោជន៍ពីកម្មវិធីណាមួយដូចតទៅ :
ម៉ាឌីខាល
ប្រាក់តូតស្តែមស៍ (Food Stamps)
ផែនការ TANF(AFDC)
ស្ត្រី ទារក ហើយនិង កុមារ (WIC)
សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
LIHEAP

ឬ

ចំនួនថវិការដ៏ធំបំផុតនៅក្នុងផ្ទះ	
(នឹងមានលទ្ធភាពនៅក្នុងថ្ងៃទី ១ ខែមិថុនា ឆ្នាំ ២០០៩ រហូតដល់ថ្ងៃទី ៣១ ខែឧសភា ឆ្នាំ ២០១០)	
ចំនួននៃមនុស្សរស់នៅក្នុងផ្ទះ:	ចំនួនថវិការដ្ឋាន រាល់ឆ្នាំ
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
សំរាប់ចំនួនសមាជិកនៃផ្ទះបន្ថែម បញ្ចូល	\$7,400

លក្ខខណ្ឌចំពោះការចូលរួម

- សំបុត្រទារលុយហ្គាសត្រូវតែមានឈ្មោះ និងអសយដ្ឋានរបស់លោកអ្នក ហើយត្រូវតែមានអសយដ្ឋានចំបងរបស់លោកអ្នក ។
- លោកអ្នកមិនត្រូវធ្វើដាក់ឈ្មោះកូនជាតូនបិតនៅក្នុងបន្ទុកសំអាងទៅលើថវិកានៃនរណាម្នាក់ទៀត ជាជាងប្រពន្ធឬប្តីរបស់លោកអ្នកឡើយ ។
- លោកអ្នកត្រូវតែដាក់ស្នើសុំការបញ្ជាក់ម្តងទៀតចំពោះក្រដាសសុំរបស់លោកអ្នក នៅពេលស្នើសុំ ។
- លោកអ្នកត្រូវតែប្រាប់ក្រុមហ៊ុន The Gas Company អោយដឹងយ៉ាងហោចណាស់ ៣០ថ្ងៃ បើលោកអ្នកពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានទៀតទេ ។
- លោកអ្នកប្រហែលជាត្រូវបានស្នើសុំអោយបញ្ជាក់នូវលក្ខណៈគ្រប់គ្រាន់ទទួលបានសំរាប់ការថែទាំ ។

កម្មវិធីនិងសេវាកម្មទៀត ដែលលោកអ្នកមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាននឹងទទួលបាន :

- **ដាប (DAP)** – កម្មវិធីនៃជំនួយផ្ទាល់, ជាកម្មវិធីសំរាប់ការប្រើប្រាស់ម៉ោងពលដែលមានប្រសិទ្ធភាពទាប ផ្តល់ជាការចុះតម្លៃចំពោះការសន្សំសំចៃម៉ោងពល នៅក្នុងផ្ទះ ដោយមិនអស់លុយ ដូចជាការដាក់ទ្រនាប់នៅលើពិភាន បន្ទះបិទបង្ហាញធាតុអាកាសតាមបន្លោះទ្វារ ការបិទថ្នាំការបិទ និងការជួសជុលគិតត្រឹមតម្លៃចុះតម្លៃសំបែង ។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-888-427-1345 ។
- **ម៉ាឌីខាល បេសឡាញ (Medical Baseline)** – ផ្តល់ជាការប្រាក់ជំនួយខាងហ្គាស ដោយមានតម្លៃថោក ចំពោះអ្នកទិញ ។ សំរាប់ព័ត៌មានបន្ថែម សូម ទូរស័ព្ទលេខ 1-888-427-1345។
- **លីហ្សេប (LIHEAP)** – កម្មវិធីជំនួយខាងម៉ោងពលនៃផ្ទះសំបែងដែលមានថវិកាតិច ជំនួយបណ្តោះអាសន្នខាងសំបុត្រទារលុយ ហើយនិងសេវាកម្មខាងរំដោះ ធាតុអាកាស ។ ទូរស័ព្ទក្រសួងសេវាកម្មនិងវឌ្ឍនភាពកម្មប្រចាំស្រុកនៃរដ្ឋកាលីហ្វ័រញ៉ា លេខ 1-866-675-6623 ។
- **ខ្សែជីវិត California Lifeline (ULTS)** – លទ្ធភាពចំពោះទូរស័ព្ទដោយមានតម្លៃថោក សំរាប់អ្នកទិញដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាននៃថវិកា ស្រដៀងគ្នានឹងកម្មវិធីវិយារ (CARE)។ សំរាប់ព័ត៌មានបន្ថែម សូមទាក់ទងអ្នកផ្តល់សេវាកម្មខាងទូរស័ព្ទប្រចាំស្រុករបស់លោកអ្នក ។

សំរាប់ព័ត៌មានអំពីកម្មវិធីវិយារ (CARE) ទូរស័ព្ទហៅក្រុមហ៊ុនហ្គាស លេខ: 1-888-427-1345

**ЗАЯВЛЕНИЕ НА 20% СКИДКУ
ПО ПРОГРАММЕ CARE****БЛАНК ЗАЯВЛЕНИЯ НА СНИЖЕННЫЙ ТАРИФ ЗА ПОЛЬЗОВАНИЕ
ЭНЕРГОРЕСУРСАМИ В ШТАТЕ КАЛИФОРНИЯ**

Компания The Gas Company предлагает сниженный тариф за пользование энергоресурсами в штате Калифорния (программа CARE). 20% скидка предоставляется правомочным индивидуумам и семьям и отражается в их ежемесячном счете за пользование услугами. Подающие заявление на программу CARE и официально утвержденные индивидуумы в течение 90 дней после открытия нового счета получают также \$15-ую скидку на оплату за установление услуг (Service Establishment Charge).

Чтобы проверить, имеете ли вы право на получение скидки, прочтите необходимые условия ниже. Пожалуйста, заполните бланк и отошлите его в предоставленном конверте в течение 90 дней. Скидка будет высчитана, после того как ваше заполненное и подписанное заявление будет утверждено компанией The Gas CompanySM.

ВЫ ИМЕЕТЕ ПРАВО НА СКИДКУ ПО ПРОГРАММЕ CARE В ДВУХ СЛУЧАЯХ:

ЕСЛИ ВЫ ПОЛУЧАЕТЕ ФЕДЕРАЛЬНЫЕ ПРОГРАММЫ ПОМОЩИ:	ВАШ ОБЩИЙ СЕМЕЙНЫЙ ДОХОД НЕ ПРЕВЫШАЕТ:	
Если вы или кто-либо, живущий с вами, получает компенсации по одной из следующих программ:	<i>(утверждено на период с 1 июня 2009 до 31 мая 2010)</i>	
Medi-Cal Food Stamps TANF(AFDC) Women, Infant & Children (WIC) Healthy Families Categories A&B LIHEAP	ИЛИ	
	Кол-во членов семьи	Общий годовой доход
	1-2	30,500\$
	3	35,800\$
	4	43,200\$
	5	50,600\$
	6	58,000\$
	За каждого дополнительного члена семьи добавьте 7,400\$	

УСЛОВИЯ ДЛЯ УЧАСТИЯ В ПРОГРАММЕ

- Счет за пользование газом должен быть оформлен на ваше имя и приходиться на ваш официальный адрес.
- Вы не оформлены иждивенцем в налоговой декларации какого-либо другого индивидуума за исключением вашего супруга (супруги).
- Вы обязаны будете перерегистрировать данное заявление по нашему требованию.
- Вы обязаны уведомить компанию The Gas Company в течение 30 дней, если вы теряете право на данную программу.
- От вас может потребоваться подтверждение вашего права на получение скидки по программе CARE.

ДРУГИЕ ПРОГРАММЫ, НА КОТОРЫЕ ВЫ МОЖЕТЕ ПОДПИСАТЬСЯ:

- **DAP** – Программа прямой помощи (Direct Assistance Program) – это программа по увеличению эффективности использования энергоресурсов для малообеспеченных семей, она предлагает бесплатные услуги по ремонту, такие как теплоизоляция потолков, герметизацию дверных прокладок, уплотнение внутренних стыков и небольшие ремонтные работы. За дополнительной информацией обращайтесь по телефону 1-888-427-1345.
- **Medical Baseline** – данная программа предоставляет скидки за дополнительное использование газа клиентам с определенными заболеваниями. За дополнительной информацией обращайтесь по телефону 1-888-427-1345.
- **LIHEAP** – Специальная программа помощи для малообеспеченных семей (Low Income Home Energy Assistance Program) предлагает помощь по оплате определенных домашних счетов, - в чрезвычайных ситуациях, при оплате строительных услуг с учетом климатических особенностей района и т.д. Звоните в калифорнийский Отдел коммунально-бытового обслуживания по телефону 1-866-675-6623.
- **California Lifeline (ULTS)** - Скидки на телефонные расценки для клиентов на похожих условиях программы CARE. За дополнительной информацией обращайтесь непосредственно в свою телефонную компанию.

ДЛЯ ПОЛУЧЕНИЯ ИНФОРМАЦИИ О ПРОГРАММЕ CARE, ЗВОНИТЕ В ОФИС КОМПАНИИ THE GAS COMPANY: 1-888-427-1345

**APPLICATION PARA SA 20%
NA DISKUWENTO SA CARE****APPLICATION PARA SA CALIFORNIA ALTERNATE RATES FOR ENERGY**

Ang California Alternate Rates for Energy (CARE) program ng The Gas Company ay nagbibigay ng 20% diskuwento sa buwanang gas bill para sa mga karapat-dapat na sambahayan. Para doon sa mga naging kwalipikado at naaprubahan sa loob ng 90 araw mula sa pag-uumpisa ng bagong serbisyong gas, ang mga ito ay makakatanggap din ng \$15 na diskuwento mula sa Service Establishment Charge. Pakisuyong kumpletuhin ang form na ito at ibalik sa loob ng 90 araw.

Upang matiyak kung kayo ay kwalipakado, basahin ang mga kinakailangan na nakatala sa ibaba. Mangyaring kumpletuhin ang application form at ibalik ito sa ibinigay na sobre. Ibibigay ang diskuwento kapag naaprubahan ng The Gas CompanySM ang inyong kumpleto at nilagdaang application form.

MAY 2 PARAAN UPANG MAGING KWALIPIKADO PARA SA DISKUWENTONG CARE:

MGA PROGRAMANG NAGBIBIGAY NG TULONG SA MADLA:
Kung kayo o ibang tao sa inyong sambahayan ay tumatanggap ng benepisyo galing sa alinman sa sumusunod na programa:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infant & Children (WIC)
Healthy Families Categories A&B
LIHEAP

O

PINAKAMATAAS NA KITA NG SAMBAHAYAN: <i>(may-bisa Hunyo 1, 2009 hanggang Mayo 31, 2010)</i>	
Bilang ng Tao sa Sambahayan	Kabuuang Kita para sa Taon
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Para sa bawat karagdagang miyembro ng bahay, magdagdag ng	\$7,400

MGA KONDISYON SA PAGLAHOK

- Ang gas bill ay kinakailangang nasa inyong pangalan, at ang nakalahad na tirahan ay ang siya ninyong pangunahing tirahan.
- Kayo ay dapat hindi nakatala bilang "dependent" sa income tax return ng iba maliban sa income tax return ng inyong asawa.
- Kailangan ninyong patotohanang muli ang inyong application kapag ito'y hiniling.
- Kailangan ninyong ipahayag sa The Gas Company sa loob ng 30 araw kung hindi na kayo kwalipikado.
- Maaari kayong hilingin na patunayan ang inyong pagiging karapatdapat sa CARE.

MGA IBANG PROGRAMA O SERBISYO NA MAARI KAYONG MAGING KWALIPIKADO:

- **DAP** - Direct Assistance Program, isang programa para sa mas matipid na paggamit ng enerhiya, para sa mga taong may mababang kita, ay nag-aalok ng mga libreng pagpapa-ayos ng bahay upang makatipid sa enerhiya gaya ng insulasyon sa kisame, weather-stripping sa pintuan, caulking at maliliit na pagpapakumpuni ng bahay. Para sa karagdagang impormasyon, mangyaring makipag-alam sa 1-888-427-1345.
- **Medical Baseline** - Nagbibigay ng karagdagang palabis na gas sa mas mababang presyo sa mga mamimili na may mga tiyak na kalagayang medikal. Upang makatanggap ng karagdagang impormasyon, tumawag sa 1-888-427-1345.
- **LIHEAP** - Low Income Home Energy Assistance Program ay nagbibigay ng tulong sa pagbayad ng mga kuwenta, tulong sa pagbayad ng mga kuwenta kapag may emerhensiya at mga serbisyo ukol sa weatherization. Makipag-alam sa California Department of Community Services and Development sa 1-866-675-6623.
- **California Lifeline (ULTS)** - Paglapit sa CARE sa pamamagitan ng telepono na may diskuwento para sa mga mamimiling ang kita ay tumatalima sa mga kagayang tuntunin ukol sa kita. Upang makatanggap ng karagdagang impormasyon, makipag-alam sa inyong tagabigay ng lokal na serbisyong telepono.

**UPANG MAKATANGGAP NG IMPORMASYON TUNGKOL SA CARE,
TAWAGAN ANG GAS COMPANY SA: 1-888-427-1345**



Application para sa CARE 20% Diskuwento sa Singil

(Pakisuyong gumamit ng madilim na tinta at sumulat ng malinaw upang makasiguro ng tamang paghanda)

Form 6491-B (05/09) TAG

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Pangalan ng Mamimili:

Tirahan: Lugar / Numero ng Apartamento

Lungsod: Zip Code:

Numero ng Kuwenta: Source Code: 9B

1 Kabuuan ng bilang ng tao sa inyong sambahayan (kasama kayo, mga ibang may sapat na edad, at mga bata):
↓
Telepono sa Bahay: - -

2A **Mga Benepisyong Natanggap galing sa mga Programang Nagbibigay ng Tulong sa Madla**
Kung kayo o ibang tao sa inyong sambahayan ay tumatanggap ng benepisyo galing sa alinman sa mga programa sa ibaba, mangyaring punuin ang bilog (●), pagkatapos HUWAG PUMUNTA SA **2B** at pumunta na agad sa **3**.

Medi-Cal: May edad na mas mababa sa 65 taong gulang
 Medi-Cal: 65 taong gulang o higit
 Food Stamps
 TANF (AFDC)
 Healthy Families A&B
 LIHEAP
 WIC

Kung HINDI ANGKOP ang anuman sa itaas, mangyaring buuin ang bahaging ito **2B.**

2B **Kita ng Sambahayan: Huwag basahin ito kung binuo ninyo ang bahagi **2A**.**
Bahagi 1: Kung hindi kayo lumalahok sa anumang programang nakatala sa itaas, mangyaring buuin ang bilog (●) para sa lahat ng pinanggagalingan ng kita ng inyong sambahayan, at ibigay ang kabuuang halaga ng kita ng inyong sambahayan sa mga puwang sa ibaba:

Social Security
 Mga Pensiyon
 SSI, SSP, SSDI
Interes o mga Dibidendo galing sa:
 Mga Savings Accounts, mga Pensiyon
 Mga Stocks o Bonds
 Mga Retirement Accounts
 Sahod o Suweldo
 Pakinabang sa Kawalan ng Trabaho
 Disability Payments
 Workers Compensation
 Scholarships, Grants, o ibang Tulong na ginagamit para sa mga Living Expenses
 Mga Legal Settlement
 Mga Insurance Settlement
 Tulong galing sa Asawa
 Child Support
 Pera at/o ibang kita
 Rental o Royalty Income
 Kita galing sa Self- Employment (IRS Form 1040, Schedule C, line 29)

Bahagi 2: Mangyaring punuin ang bilog (●) ng agwat ng kita bawat taon ng inyong sambahayan bago mga pagbabawas (deductions).

\$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

Kung higit sa \$58,000, ilagay ang halaga dito: \$, .00 bawat taon

3 **Pahayag:** Mangyaring basahin at lumagda sa ibaba.

Isinasaad ko na ang impormasyon na aking ibinigay sa aplikasyong ito ay tapat at tumpak. Sumasang-ayon ako na kung ako ay hihilingan, papatunayan ko na ako'y karapatdapat sa CARE. Sumasang-ayon din ako na ipapahayag ko sa Gas Company kung hindi na ako kwalipikadong tumanggap ng diskuwento. Nauunawaan ko na kung makatanggap ako ng diskuwento ng hindi ako kwalipikado, maaari akong hingang-pautos na ibalik ang diskuwentong natanggap ko. Nauunawaan ko na maaring ipahayag ng The Gas Company ang aking impormasyon sa mga ibang utilities o mga ahente upang matala ako sa kanilang mga programang nagbibigay ng tulong.

Lagda: X Petsa:



A Sempra Energy utility

20% CARE DISCOUNT
โบสถ์ครเข้าร่วมโครงการ

โบสถ์ครเข้าร่วมโครงการ CALIFORNIA ALTERNATE RATES FOR ENERGY

โครงการ California Alternate Rates for Energy (CARE) โดย The Gas Company มอบส่วนลด 20% ของค่าบริการการใช้ก๊าซรายเดือนให้กับครัวเรือนที่มีสิทธิ์เข้าร่วมโครงการ

ผู้ที่ผ่านข้อกำหนดและได้รับการตอบรับเข้าร่วมโครงการภายใน 90

วันหลังจากการเริ่มต้นรับบริการใช้ก๊าซธรรมชาติจะได้รับส่วนลดอีก \$15 สำหรับค่าธรรมเนียมเริ่มต้นบริการ (Service Establishment Charge) กรุณากรอกข้อมูลโบสถ์ครให้ครบถ้วนและยื่นโบสถ์ครภายใน 90 วัน

ท่านสามารถตรวจสอบหลักเกณฑ์การเข้าร่วมโครงการทางด้านล่างของเอกสารนี้
กรุณากรอกโบสถ์ครและส่งคืนโดยใส่ลงในซองที่แนบมา

ทั้งนี้ท่านจะได้รับส่วนลดต่อเมื่อท่านกรอกข้อมูลและลงนามในโบสถ์ครอย่างครบถ้วน
และหลังจากโบสถ์ครของท่านได้รับการอนุมัติจาก The Gas CompanySM

2 วิธีในการผ่านเกณฑ์สำหรับการรับส่วนลด THE CARE DISCOUNT:

โครงการความช่วยเหลือสาธารณะ: (PUBLIC ASSISTANCE PROGRAMS:)	หรือ	รายได้รวมสูงสุดของครัวเรือน: (MAXIMUM HOUSEHOLD INCOME:)	
ในกรณีที่ท่านหรือสมาชิกในครอบครัวได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้:		<i>(มีผลตั้งแต่ 1 มิถุนายน 2009 ถึง 31 พฤษภาคม 2010)</i>	
Medi-Cal Food Stamps TANF(AFDC) Women, Infant & Children (WIC) Healthy Families Categories A&B LIHEAP	จำนวนสมาชิกในครัวเรือน	รายได้รวมต่อปี	
	1-2	\$30,500	
	3	\$35,800	
	4	\$43,200	
	5	\$50,600	
	6	\$58,000	
	หากมีสมาชิกในครัวเรือนเพิ่มขึ้น 1 คน, ให้เพิ่มอีกคนละ	\$7,400	

ข้อกำหนดสำหรับผู้เข้าร่วมโครงการ

- โบเรียกเก็บเงินค่าบริการก๊าซต้องเป็นชื่อของท่านและที่อยู่ต้องเป็นที่อยู่หลักของท่าน
- ท่านต้องไม่ใช่สิทธิ์เป็นผู้อยู่ในความดูแล (Dependent) ของผู้อื่น นอกเหนือจากคู่สมรสของท่านในการเสียภาษีรายได้
- ท่านต้องแสดงหลักฐานตามที่ระบุไว้ในโบสถ์ครอีกครั้งหากมีการร้องขอ
- ท่านต้องแจ้งให้ The Gas Company ทราบภายใน 30 วัน หากท่านขาดสถานะภาพในการเข้าร่วมโครงการ
- ท่านอาจถูกร้องขอให้แสดงหลักฐานยืนยันว่าท่านมีสิทธิ์ในการเข้าร่วมโครงการ CARE

โครงการและบริการอื่น ๆ ที่ท่านอาจผ่านเกณฑ์ในการเข้าร่วม:

- **DAP - Direct Assistance Program** (โครงการให้ความช่วยเหลือโดยตรง), เป็นโครงการสำหรับผู้มีรายได้น้อย เพื่อให้ผู้เข้าร่วมโครงการสามารถใช้พลังงานได้อย่างมีประสิทธิภาพ, โครงการนี้จะมอบอุปกรณ์ประหยัดพลังงาน เช่น ฉนวนฝ้าเพดาน, ฐานใต้ประตูเพื่อกันลมและฝน, บริการการปรับปรุงและซ่อมแซมเล็กๆ น้อยๆ ในบ้าน โดยไม่คิดค่าใช้จ่ายใดๆ ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้ที่หมายเลข 1-888-427-1345
- **Medical Baseline** – (โครงการบริการทางการแพทย์ขั้นพื้นฐาน) โครงการนี้จะมอบสิทธิเพิ่มเติมในการใช้ก๊าซในอัตราต่ำกว่าราคาปกติแก่ผู้ใช้บริการที่มีอาการป่วยบางประเภท ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้ที่หมายเลข 1-888-427-1345
- **LIHEAP - Low Income Home Energy Assistance Program** (โครงการความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย) โครงการนี้จะมอบความช่วยเหลือในการชำระค่าบริการ ความช่วยเหลือในการชำระค่าบริการในกรณีเกิดเหตุฉุกเฉินและการปรับปรุงอาคารเพื่อเพิ่มประสิทธิภาพในการประหยัดพลังงาน ท่านสามารถติดต่อสอบถามข้อมูลเพิ่มเติมที่สำนักงานบริการและการพัฒนาสาธารณะแห่งรัฐแคลิฟอร์เนีย (California Department of Community Services and Development) ที่หมายเลขโทรศัพท์ 1-866-675-6623
- **California Lifeline (ULTS)** - (โครงการให้ค่าบริการปัญหาชีวิตของรัฐแคลิฟอร์เนีย) โครงการนี้จะมอบส่วนลดค่าบริการโทรศัพท์สำหรับผู้ให้บริการที่มีรายได้น้อยในเกณฑ์เดียวกับผู้มีสิทธิ์เข้าร่วมโครงการ CARE ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้จากผู้ให้บริการโทรศัพท์ในท้องถิ่นของท่าน

สอบถามข้อมูลเพิ่มเติมเกี่ยวกับโครงการ CARE ติดต่อ THE GAS COMPANY โทร. : 1-888-427-1345

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Individually Metered Residential (Form No. 6674-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



A Sempra Energy utility

YOUR RATE DISCOUNT IS EXPIRING

Dear Customer:

Date: 06/01/2009

You are currently receiving a 20% rate discount on your monthly gas bill through The Gas Company's California Alternate Rates for Energy (CARE) program. In order to continue receiving the CARE discount, you are required to renew your eligibility within 90 days. To renew, use one of two methods listed below:

1. Return the completed and signed Certification Form in the envelope provided.
- OR**
2. Call 1-866-716-3452 anytime 24 hours a day, 7 days a week, and follow the instructions to recertify by phone. Please have your account number ready. You can locate your account number at the bottom of this page,
- OR**
3. Visit our Website <http://www.socalgas.com/care/recert/> and have your account number ready.

THERE ARE 2 WAYS TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or another person in your household receives benefits from any of the following programs:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2009 to May 31, 2010)</i>	
Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Each Additional household member, add	\$7,400

CONDITIONS FOR PARTICIPATION

- The gas bill must be in your name and the address must be your primary address.
- You must not be claimed as a dependent on another person's income tax return other than your spouse.
- You must recertify your CARE eligibility when requested.
- You must notify The Gas CompanySM within 30 days if you no longer qualify.
- You may be asked to verify your eligibility for CARE.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English: 1-800-427-2200	Mandarin: 1-800-427-1429	Spanish: 1-800-342-4545
Korean: 1-800-427-0471	Cantonese: 1-800-427-1420	Vietnamese: 1-800-427-0478

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)

Account Number: 123 345 7890



CARE 20% Rate Discount Recertification Form

(Please use dark ink and print clearly to ensure proper processing)

Form 6674-B (06/09) EN

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Account Number:

Date: 06/01/2009

Customer Name:

Address:

- I no longer qualify or wish to participate in CARE. Please remove my account from the CARE program. If you filled in this circle (●), please skip Sections 1 and 2, **sign** at the bottom, and mail this form in the postage paid envelope provided within 90 days.

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

↓
Home Phone #: - -

2A **Public Assistance Programs Benefits Received:**
If you or someone in your household receives benefits from any of the programs below, please fill in the circle (●), then SKIP **2B** and go directly to **3**.

- OR**
- | | | | |
|---|-----------------------------------|--|---------------------------|
| <input type="radio"/> Medi-Cal: Under 65 of age | <input type="radio"/> Food Stamps | <input type="radio"/> Healthy Families A&B | <input type="radio"/> WIC |
| <input type="radio"/> Medi-Cal: 65 or older | <input type="radio"/> TANF (AFDC) | <input type="radio"/> LIHEAP | |

*If NONE of the above, please complete section **2B**.*

2B **Household Income: Skip if you completed section **2A**.**
Part 1: If you do not participate in any of the programs listed above, please fill in the circle (●) for all sources of income in your household, and provide your total household income in the spaces provided below:

- | | | |
|--|---|---|
| <input type="radio"/> Social Security | <input type="radio"/> Wages or Salaries | <input type="radio"/> Legal Settlements |
| <input type="radio"/> Pensions | <input type="radio"/> Unemployment Benefits | <input type="radio"/> Insurance Settlements |
| <input type="radio"/> SSI, SSP, SSDI | <input type="radio"/> Disability Payments | <input type="radio"/> Spousal Support |
| Interest or Dividends from: | <input type="radio"/> Workers Compensation | <input type="radio"/> Child Support |
| <input type="radio"/> Savings Accounts, Pensions | <input type="radio"/> Scholarships, Grants, | <input type="radio"/> Cash and/or other income |
| <input type="radio"/> Stocks or Bonds | or Other Aid Used for | <input type="radio"/> Rental or Royalty Income |
| <input type="radio"/> Retirement Accounts | Living Expenses | <input type="radio"/> Profit from Self-Employment
(IRS Form 1040, Schedule C, line 29) |

Part 2: Please fill in the circle (●) of your household's income range per year before deductions.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

If more than \$58,000, enter amount here: \$, .00 per year

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 The Gas Company if I no longer qualify to receive the 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 The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs.

Signature: X **Date:**

**SU TARIFA DE DESCUENTO
ESTÁ POR VENCER**

Apreciable cliente:

Fecha: 06/01/2009

Actualmente recibe una tarifa de descuento del 20% en su factura mensual de gas a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM. Con el fin de continuar recibiendo el descuento CARE, debe renovar su derecho a participar dentro de 90 días. Para renovarlo, use uno de los tres métodos que se enumeran a continuación:

1. Devuelva el Formulario de Certificación debidamente llenado y firmado en el sobre provisto,
ó
2. Llame al **1-866-716-3452** cuando usted guste 24 horas al día, 7 días a la semana, y siga las instrucciones para recertificar por teléfono. Por favor tenga listo su número de cuenta. Puede localizar su número de cuenta en la parte inferior de esta página,
ó
3. Visite nuestro sitio Web <http://www.socalgas.com/care/recert/> y tenga listo su número de cuenta.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)

ó

INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)</i>	
Número de personas en el hogar	Ingreso total anual
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Por cada miembro adicional en el hogar, añada	\$7,400

CONDICIONES PARA PARTICIPAR

- La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal.
- No debe aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge.
- Debe recertificar su solicitud CARE cuando se le solicite.
- Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- Tal vez se le pida comprobar que reúne los requisitos para CARE.

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200
Coreano: 1-800-427-0471

Mandarín: 1-800-427-1429
Cantonés: 1-800-427-1420

Español: 1-800-342-4545
Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

Número de cuenta: 123 345 7890



Formulario de recertificación para la tarifa CARE del 20% de descuento

Form 6674-B (06/09) SP

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

(Por favor use tinta oscura y escriba claramente con letra de molde para asegurar el procesamiento apropiado)

Número de cuenta:

Fecha: 06/01/2009

Nombre del cliente:

Domicilio:

- Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE. Si rellenó este círculo (●), por favor **vaya directamente a la sección 3, firme** en la parte de abajo, y envíe este formulario en el sobre con porte pagado provisto en un término de 90 días.

1 Número total de personas que viven en su hogar (incluyase usted, otros adultos y niños):

Teléfono de casa: - -

2A **Beneficios que recibe a través de programas de asistencia pública:**
Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas demostrados, por favor rellene el círculo (●), y vaya directamente a la sección **3**.

- Medi-Cal: menor de 65 años
- Food Stamps
- Healthy Families A&B
- WIC
- Medi-Cal: 65 años o más
- TANF (AFDC)
- LIHEAP

0 *Si no marcó NINGUNO, sírvase llenar la sección **2B**.*

2B **Ingreso en el hogar:**
Parte 1: Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el círculo (●) para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- Seguro Social
- Pensiones
- SSI, SSP, SSDI
- Salarios o sueldos
- Beneficios de desempleo
- Pagos de incapacidad
- Pagos de reclamaciones legales
- Pagos de reclamaciones a seguros
- Pensión conyugal
- Pensión alimenticia
- Dinero en efectivo y/u otros ingresos
- Ingresos por alquiler o regalías
- Utilidades de autoempleo (Formulario 1040, Anexo C, Renglón 29 del IRS)
- Intereses o dividendos de:
 - Cuentas de ahorro,
 - Pensiones
 - Acciones o bonos
 - Cuentas para el retiro
 - Indemnización para los trabajadores
 - Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida

Parte 2: Sírvase rellenar el círculo (●) de la gana que corresponde al ingreso anual de su hogar antes de deducciones.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000
- Si es más de \$58,000, escriba el monto aquí: \$, .00 al año

3 **Declaración:** Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia con requisitos de ingreso.

Firma : X

Fecha:



親愛的客戶:

日期: 月/日/年

您現在正通過 **The Gas CompanySM** (瓦斯公司) 的加州能源優惠率(CARE)計劃, 享受占每月瓦斯(煤氣)帳單 **20%** 的 CARE 折扣優惠。若要繼續享有 CARE 計劃的折扣, 您需要在 90 天內再認證您仍符合資格。您可以以下二種方式之一來重新認證你的資格:

1. 填寫好並在重新認證表格 (Certification Form) 上簽名, 用所提供的信封寄回。

或者

2. 訪問網站 <http://www.socalgas.com/care/recert/>, 上網前請準備好您的帳戶號碼。

符合 CARE 折扣的兩種資格:

政府協助計劃:
如果您或您的家人從下列任一計劃中受益
Medi-Cal - 加州醫療輔助計劃
Food Stamps - 食物券
TANF(AFDC) - 貧困家庭臨時現金資助計劃
Women, Infants & Children (WIC) - 婦女, 嬰兒和兒童營養輔助計劃)
Healthy Families Categories A&B - 健康家庭低費兒童醫療健保計劃類別 A 及 B
LIHEAP - 低收入家庭能源協助計劃

或

家庭收入最高限額: (有效期 2009 年 6 月 1 日至 2010 年 5 月 31 日)	
家庭成員人數	年收入總額
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
每多一位家庭成員, 增加	\$7,400

參加條件

- 瓦斯帳單必須在您的名下並且地址必須為您的主要住宅。
- 除您配偶外, 您不能是其他人報稅單上的被撫養人。
- 您必須在被要求時, 重新認證您還符合 CARE 資格。
- 如果您已經不再符合該資格, 您必須在 30 天內通知 **The Gas Company**。
- 您可能被要求提供符合 CARE 資格的證明文件。

若需更多關於 CARE 計劃的諮詢, 請致電 THE GAS COMPANY:

英語: 1-800-427-2200

國語: 1-800-427-1429

西班牙語: 1-800-342-4545

韓語: 1-800-427-0471

粵語: 1-800-427-1420

越南語: 1-800-427-0478

聽覺障礙專線 (TDD/TTY): 1-800-252-0259 (僅提供英語和西班牙語服務)

帳戶號碼: 123 456 7890



CARE 20% 費率折扣資格重新認證表格

(請用深色筆以正楷填寫清晰以確保適當受理)

Form 6674-B (06/09) CH

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

帳戶號碼:

日期: 06/01/2009

客戶姓名:

地址:

我不再符合或不願再參加 CARE 計劃。請把我的賬戶從 CARE 計劃中取消。如果您將這個圓圈塗黑(●)，請跳過第一和第二部分的內容，在文件下方簽字，將此表格放在所提供的郵資已付的信封中，在 90 天內寄回。

1 您家庭中的總人數 (包括您本人, 其他成年人和兒童):

住宅電話 #: - -

2A 所接受的政府協助計劃福利:
請把您或您家人所接受福利的計劃前塗黑(●), 然後略過 **2B** 直接到 **3**。

- Medi-Cal (加州醫療輔助計劃): 低於 65 歲
- Medi-Cal (加州醫療輔助計劃): 65 或更大年齡
- WIC (婦女, 嬰兒和兒童營養輔助計劃)
- Healthy Families Categories A&B (健康家庭低費兒童醫療健保計劃類別 A 及 B)
- Food Stamps (食物券)
- TANF (AFDC) (貧困家庭臨時現金資助計劃)
- LIHEAP (低收入家庭能源協助計劃)

如果以上都不是, 請填寫下一個部分 **2B**。

2B 家庭收入: 請跳過這部分內容如果您已經填寫了 **2A** 部分。

第一部分: 如果您沒有參加以上任何計劃, 請把您家庭收入所有來源前面的圓圈塗黑(●), 並在下方提供的空間內提供您的家庭收入總額:

- 社會安全福利金 (Social Security)
- 退休金
- SSI, SSP, SSDI (社會安全補助金)
- 從以下項目獲取的利息或紅利:
 - 儲蓄賬戶, 退休金
 - 股票或債券
 - 退休賬戶
- 工資或薪金
- 失業救濟金
- 殘疾津貼
- 勞工補償
- 獎學金, 助學金, 或其它用于支付生活費用的助學津貼
- 法律賠償
- 保險賠償
- 配偶支付的贍養費
- 子女贍養費
- 現金或其它收入
- 租金或權利金收入
- 自由業收入 (IRS 1040 表格, Schedule C 表格, 第 29 行)

第二部分: 請按照您的稅前家庭年收入, 把適當項目前的圓圈塗黑(●)

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000

如果多於 \$58,000, 請在此處填寫金額: \$, .00 每年

3 聲明: 請您閱讀並簽字。

我願意證明上述申請資料正確屬實。若需要我也同意提供文件證明符合 CARE 的資格。我同意若我不再符合條件時, 即通知 The Gas Company。我瞭解若不合格接受折扣, 我可能須退還我之前所接受的折扣。我瞭解 The Gas Company 可將有關我的資料提供給其他的公用事業公司和組織團體以協助我加入他們的協助計劃。

簽名: X

日期:



귀하의 요금 할인이 종료됩니다

친애하는 고객님:

귀하께서는 현재 The Gas CompanySM의 캘리포니아 에너지 대체 요금 (CARE) 프로그램을 통하여 월별 가스 요금에 대해 20% 할인을 받고 계십니다. CARE 할인을 계속 받으시려면, 90 일 내에 수혜 자격을 갱신하셔야 합니다. 아래에 나열된 두 방법 중 하나를 사용하여 갱신을 하실 수 있습니다.

1. 제공된 봉투를 사용하여 작성하고 서명한 증명 양식을 제출합니다
또는
2. 구좌 번호를 갖추고 저의 웹사이트 <http://www.socalgas.com/care/recert/> 를 방문하여 갱신에 임하실 수 있습니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:
귀하나 기타 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:
Medi-Cal
Food Stamps (푸드 스탬프)
TANF(AFDC)
Women, Infants & Children (WIC, 여성, 유아 및 아동)
Healthy Families A&B (건강한 가족 유형 A 및 B)
LIHEAP

또는

최대 가구 소득: (2009. 6. 1 부터 2010. 5. 31 까지 유효)	
가구의 식구 수	총 연간 소득
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
추가되는 식구 1인당 추가액	\$7,400

참여 조건

- 가스 청구서는 귀하의 이름으로 되어 있어야 하며 주소는 귀하의 주 주소이어야 합니다.
- 배우자 이외에 다른 사람이 소득세 보고서에서 귀하를 부양가족으로 청구하지 않아야 합니다.
- 요청할 경우 CARE 수혜 자격을 재증명해야 합니다.
- 더 이상 수혜 자격이 없는 경우 30 일 이내에 The Gas Company 에 통보해야 합니다.
- CARE 에 대한 수혜자격을 증명하도록 요청 받을 수 있습니다.

CARE 에 대한 사항은 아래의 THE GAS COMPANY 번호로 문의하십시오:

영어: 1-800-427-2200

북경어: 1-800-427-1429

스페인어: 1-800-342-4545

한국어: 1-800-427-0471

광둥어: 1-800-427-1420

월남어: 1-800-427-0478

청각 장애인(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)



CARE 20% 요금 할인 재증명 양식

(정확히 처리되도록 하기 위해 진한 펜을 사용하여 분명히 인쇄체로 기입)

Form 6674-B (06/09) KO

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

번호:

날짜: 06/01/2009

고객 이름:

주소:

- 본인은 더 이상 자격이 없거나 CARE에 참여하기를 원치 않습니다. 본인의 구좌를 CARE 프로그램에서 삭제하십시오. 이 동그라미(●) 안을 채운 경우, 1번 및 2번을 생략하고 하단에 서명하여 이 양식을 제공된 우송료 선불 봉투에 넣어 90일 내에 우송하십시오.

1 귀 가구의 총 식구 수 (귀하, 다른 성인 및 어린이 포함):

주택 전화번호: - -

2A 받는 공공 지원 프로그램 혜택:
귀하나 식구 중에서 혜택을 받는 프로그램에 대해서는 동그라미(●) 안을 채우고 **2B**번을 건너뛰어 직접 **3**번으로 가십시오.

- Medi-Cal: 65 세 미만
- Food Stamps
- Healthy Families A&B
- WIC
- Medi-Cal: 65 세 이상
- TANF (AFDC)
- LIHEAP

위의 프로그램 중 어느 것도 해당되지 않으면, 다음의 **2B**번을 작성하십시오.

가구 소득: **2A** 번을 작성한 경우 건너뛰십시오.

2B **1부:** 위에 나열된 어느 프로그램에도 참여하지 않으시는 경우, 귀 가구의 모든 소득원에 대해 동그라미(●) 안을 채우고 아래에 있는 공란에 총 가구 소득을 기입하십시오:

- 사회보장금
 - 연금
 - SSI, SSP, SSDI
 - 다음 사항으로부터의 이자나 배당금:
 - 예금 구좌, 연금
 - 주식이나 채권 또는
 - 은퇴 구좌
 - 임금 또는 봉급
 - 실업 혜택
 - 장애 지원금
 - 산재보상금
 - 장학금, 보조금, 또는 다음 사항을 위해 사용된 기타 보조금 생활비
 - 법적 타협금
 - 보험 타협금
 - 배우자 생활비
 - 자녀 부양비
 - 현금 및/또는 기타 소득
 - 임대료나 로열티 소득
 - 자영업 수익
- (IRS 양식 1040, 스케줄 C, 29 행)

2부: 귀 가구의 공제전 연간 소득 범위에 해당되는 항목의 동그라미(●) 안을 채우십시오.

\$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

\$58,000 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 \$, .00

3 **진술:** 아래 사항을 읽고 서명하십시오:

본 신청서에서 제시한 정보가 정확한 사실임을 진술합니다. 본인은 요청 받을 경우 CARE 수혜 자격 증거자료를 제출하기로 동의하였습니다. 본인이 할인을 받을 자격이 더 이상 없게 될 경우 The Gas Company에 통보함에 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수 있다는 것을 본인은 이해합니다. The Gas Company에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에 등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: X

날짜:



Kính Gởi Quý Khách Hàng:

Ngày: MM/DD/YY

Quý vị hiện đang được giảm giá 20% trên biên nhận gas hàng tháng qua chương trình Mức Giá Năng Lượng Thay Thế của California (California Alternate Rates for Energy hay CARE) của The Gas CompanySM. Để tiếp tục được giảm giá theo chương trình CARE, quý vị được yêu cầu phải gia hạn hồ sơ chứng minh sự hội đủ điều kiện của mình trong vòng 90 ngày. Để gia hạn hồ sơ, xin dùng một trong hai cách được liệt kê dưới đây:

- Gởi trả Mẫu Giấy Chứng Nhận được điền đầy đủ và ký tên trong phong bì được cung cấp sẵn.

HOẶC

- Vào trang mạng của chúng tôi <http://www.socalgas.com/care/recert/> và chuẩn bị sẵn số trương mục của quý vị.

CÓ 2 CÁCH ĐỂ HỘI ĐỦ ĐIỀU KIỆN ĐƯỢC GIẢM GIÁ THEO CHƯƠNG TRÌNH CARE:

CÁC CHƯƠNG TRÌNH TRỢ GIÚP CÔNG CỘNG:
Nếu quý vị hay người nào khác trong hộ gia đình của quý vị nhận trợ cấp từ bất cứ chương trình nào sau đây:
Medi-Cal
Phiếu Thực Phẩm (Food Stamps)
TANF(AFDC)
Phụ Nữ, Trẻ Sơ Sinh & Trẻ Em (Women, Infants & Children hay WIC)
Gia Đình Khỏe Mạnh Loại A&B (Healthy Families Categories A&B)
LIHEAP

HOẶC

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH: (có hiệu lực từ ngày 1 tháng Sáu, 2009 đến 31 tháng Năm, 2010)	
Số Người trong Hộ Gia Đình	Tổng Lợi Tức Hàng Năm
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Mỗi người Thêm vào trong Hộ Gia Đình, được cộng thêm	\$7,400

ĐIỀU KIỆN ĐỂ THAM GIA

- Quý vị phải là người đứng tên trong biên nhận gas và địa chỉ phải là địa chỉ chính của quý vị.
- Quý vị không được là người tùy thuộc trong hồ sơ khai thuế của người khác ngoại trừ người phối ngẫu của mình.
- Quý vị phải tái xác nhận sự hội đủ điều kiện của mình theo chương trình CARE khi được yêu cầu.
- Quý vị phải thông báo cho The Gas Company trong vòng 30 ngày nếu quý vị không còn hội đủ điều kiện nữa.
- Quý vị có thể được yêu cầu thẩm tra tình trạng hội đủ điều kiện của mình cho chương trình CARE.

ĐỂ BIẾT THÊM THÔNG TIN VỀ CHƯƠNG TRÌNH CARE, XIN GỌI CHO THE GAS COMPANY TẠI:

Tiếng Anh: 1-800-427-2200

Quan Thoại: 1-800-427-1429

Tây Ban Nha: 1-800-342-4545

Đại Hàn: 1-800-427-0471

Quảng Đông: 1-800-427-1420

Tiếng Việt: 1-800-427-0478

Số Máy dành cho Người Khiếm Thính (TDD/TTY): 1-800-252-0259 (chỉ có sẵn bằng tiếng Anh và tiếng Tây Ban Nha)

Số Trương Mục: 123 456 7890



Đơn Xin Giảm Giá 20% Theo Chương Trình CARE

(Xin dùng mực đậm và viết bằng chữ in để đảm bảo xét duyệt chính xác)

Form 6674-B (06/09) VI

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



Số Trương Mục:

Ngày: 06/01/2009

Tên Khách Hàng:

Địa chỉ:

- Tôi không còn hội đủ điều kiện hoặc không muốn tham gia vào chương trình CARE nữa. Xin rút trương mục của tôi ra khỏi chương trình CARE. Nếu quý vị bôi đen vào vòng tròn này (●), xin bỏ qua Phần 1 và 2, **ký tên** ở dưới, và gửi mẫu đơn này vào phong bì được cung cấp sẵn đã trả bưu phí trước trong vòng 90 ngày.

1 Tổng số người trong hộ gia đình của quý vị (bao gồm quý vị, người lớn khác, và trẻ em):

Điện Thoại Nhà #: - -

2A

Các Trợ Cấp từ các Chương Trình Trợ Giúp Công Cộng (Public Assistance Programs):

Hãy bôi đen vào vòng tròn (●) cho bất cứ chương trình nào mà quý vị hay ai đó trong gia đình của quý vị nhận trợ cấp, sau đó BỎ QUA phần **2B** và điền vào phần **3**.

- Medi-Cal: Dưới 65 tuổi Food Stamps Healthy Families A&B WIC
 Medi-Cal: 65 tuổi trở lên TANF (AFDC) LIHEAP

HOẶC

Nếu KHÔNG có mục nào ở trên, hãy điền vào Phần **2B.**

2B

Lợi Tức Hộ Gia Đình: Bỏ qua phần này nếu quý vị đã điền vào Phần **2A**.

Phần 1: Nếu quý vị không tham gia vào bất cứ chương trình nào được liệt kê ở trên, xin bôi đen vào vòng tròn (●) cho tất cả các nguồn lợi tức của hộ gia đình quý vị, và cung cấp tổng lợi tức gia đình của quý vị vào các khoảng trống bên dưới:

- | | | |
|--|--|---|
| <input type="radio"/> An Sinh Xã Hội | <input type="radio"/> Lương tuần hay lương tháng | <input type="radio"/> Bồi Thường theo Pháp Luật |
| <input type="radio"/> Hưu Bổng | <input type="radio"/> Trợ Cấp Thất Nghiệp | <input type="radio"/> Bồi Thường Bảo Hiểm |
| <input type="radio"/> SSI, SSP, SSDI | <input type="radio"/> Trợ Cấp Tàn Phế | <input type="radio"/> Tiền Nuôi Người Phối Ngẫu |
| Lợi Tức hay Cổ Tức từ: | <input type="radio"/> Bồi Thường Lao Động | <input type="radio"/> Tiền Nuôi Con Cái |
| <input type="radio"/> Trương Mục Tiết Kiệm, Hưu bổng | <input type="radio"/> Học Bổng, Tài Trợ hay Trợ | <input type="radio"/> Lợi Tức Tiền Mặt và/hoặc lợi tức khác |
| <input type="radio"/> Cổ Phiếu hay Trái Phiếu, hoặc | Giúp Khác Dùng để trang | <input type="radio"/> Lợi Tức Khi Cho Thuê hay Tiền Bản Quyền |
| <input type="radio"/> Trương Mục Hưu Trí | trả Chi Phí Sinh Hoạt | <input type="radio"/> Lợi nhuận khi Làm Việc Tự Do(Mẫu đơn |
| | | 1040, Bản Kê C, dòng 29 của IRS) |

Phần 2: Hãy bôi đen vào vòng tròn (●) mức lợi tức hàng năm của hộ gia đình trước khi khấu trừ.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

Nếu nhiều hơn \$58,000, xin điền tổng số vào đây: \$, .00 mỗi năm

3 Lời Khai: Xin đọc và ký bên dưới.

Tôi xin khai rõ rằng thông tin mà tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý sẽ cung cấp bằng chứng về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý thông báo cho The Gas Company biết nếu tôi không còn hội đủ điều kiện để nhận giảm giá nữa. Tôi hiểu rằng nếu tôi được giảm giá khi không hội đủ điều kiện, tôi có thể được yêu cầu phải trả lại khoản giảm giá mà tôi đã nhận. Tôi hiểu rằng The Gas Company có thể chia sẻ thông tin của tôi với các hãng tiện ích khác hoặc các đại lý để ghi danh tôi vào các chương trình trợ giúp của họ.

Chữ ký: X

Ngày:

SAMPLE FORMS: APPLICATIONS
Capitation Program CARE Application
(Form No. 6491-2B, 05/09)

T
T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H11

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



A Sempra Energy utility®

CARE

20% DISCOUNT

The Gas Company's California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households. Those who qualify and are approved within 90 days of starting new gas service will also receive a \$15 discount on the Service Establishment Charge.

To see if you qualify, check the requirements shown below. Please complete the application and return it to The Gas CompanySM. The discount will be applied once your completed and signed application is approved by The Gas Company or you can apply online at www.socalgas.com/assistance/.

THERE ARE TWO WAYS TO QUALIFY FOR THE CARE DISCOUNT:

1 PUBLIC ASSISTANCE PROGRAMS:

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

- Medi-Cal
- Food Stamps
- TANF(AFDC)
- Women, Infants & Children (WIC)
- Healthy Families Categories A&B
- LIHEAP

2 MAXIMUM HOUSEHOLD INCOME:

(effective June 1, 2009 to May 31, 2010)

Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
For each additional household member, add \$7,400	

←OR→

CONDITIONS FOR PARTICIPATION

1) The gas bill must be in your name and the address must be your primary address. 2) You may not be claimed as a dependent on another person's income tax return other than your spouse's. 3) You will need to recertify your application when requested. 4) You are required to notify The Gas Company 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:

- **DAP** – Direct Assistance Program, offers no-cost energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repair to qualified customers. 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.
- **LIHEAP** – Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Department of Community Services and Development at 1-866-675-6623.
- **California Lifeline (ULTS)** – A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English: 1-800-427-2200

Mandarin: 1-800-427-1429

Spanish: 1-800-342-4545

Korean: 1-800-427-0471

Cantonese: 1-800-427-1420

Vietnamese: 1-800-427-0478

Hearing Impaired (TDD/TYY): 1-800-252-0259 (available in English and Spanish only)



El programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM ofrece un descuento del 20% en la factura mensual de gas a los hogares que reúnen los requisitos. Aquellos que califiquen y sean aprobados en un término de 90 días a partir del inicio de su servicio de gas también recibirán un descuento de \$15 en el cargo de establecimiento de servicio (cargo de conexión inicial).

Para ver si califica, revise los requisitos que aparecen a continuación. Por favor llene el formulario de solicitud y regréselo a The Gas Company. El descuento se aplicará una vez que el formulario de solicitud debidamente llenado y firmado haya sido aprobado por The Gas Company o puede aplicar en línea en www.socalgas.com/sp/asistencia/.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

1 PROGRAMAS DE ASISTENCIA PÚBLICA:

Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:

- Medi-Cal
- Food Stamps
- TANF(AFDC)
- Women, Infants & Children (WIC)
- Healthy Families Categories A&B
- LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)

2 INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)

Número de personas en el hogar	Ingreso total anual
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Por cada miembro adicional en el hogar, añada \$7,400	



CONDICIONES PARA PARTICIPAR

- 1) La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal.
- 2) No puede aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge.
- 3) Debe recertificar su solicitud CARE cuando se le solicite.
- 4) Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- 5) Tal vez se le pida comprobar que reúne los requisitos para CARE.

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE QUIZÁ PUDIERA CALIFICAR:

- **Programa de Asistencia Directa (DAP):** Este programa de eficiencia energética para clientes que califican ofrece mejoras gratuitas para el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a fin de ahorrar energía. Para más información, por favor llame al 1-800-331-7593.
- **Asignación Médica Inicial (Medical Baseline):** Provee asignación adicional de gas a una tarifa menor a los clientes con ciertas afecciones médica. Para más información, llame al 1-800-342-4545.
- **Programa de Ayuda Energética para Hogares de Bajos Recursos (LIHEAP):** Ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y servicios de acondicionamiento contra las inclemencias del tiempo. Llame al Departamento de Servicios a la Comunidad de California al 1-866-675-6623.
- **Servicio Telefónico Universal Lifeline (California Lifeline-ULTS):** Acceso telefónico a precios de descuento para los clientes que reúnan requisitos de ingreso similares a los del programa CARE. Para más información, llame al proveedor de servicio telefónico de su localidad.

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200

Mandarín: 1-800-427-1429

Español: 1-800-342-4545

Coreano: 1-800-427-0471

Cantonés: 1-800-427-1420

Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TYY): 1-800-252-0259 (disponible en inglés y español únicamente)

SAMPLE FORMS: APPLICATIONS
Post-Enrollment Verification CARE Application
Individually Metered Residential (Form No. 6675-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



**IMMEDIATE REPLY
NEEDED**



Dear Customer:

Date: 06/01/2009

You are currently receiving a 20% CARE discount on your monthly gas bill through The Gas Company's California Alternate Rates for Energy (CARE) program. Your household has been randomly selected for verification of eligibility. To continue receiving this discount, please return the completed and signed form including required document(s) in the envelope provided within 90 days. If you do not reply or are found ineligible, you may receive corrected billings.

Required Documents: You only need to provide copies of document(s) from either list 1 OR 2 (not both).

List 1) If you or another person in your household receives public assistance, please send documentation proving participation in any of the following programs:

Medi-cal	Food Stamps	TANF (AFDC)	WIC	Healthy Families A&B * Please provide a copy of the premium amount paid	LIHEAP
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OR

List 2) If no one in your household participates in any of the programs mentioned above, please send copies of income documents for every household member receiving income or aid. The chart below lists income sources and required documents:

If you receive:	Acceptable Documents
Wages, Salary, Tips, Commissions	Two most recent consecutive Pay Stubs, or W2, or IRS 1040 form
Social Security, SSI, SSDI, Pensions, Disability Payments, Workers Compensation, Unemployment Benefits	Statements of Benefits, or Copy of the Check, or Bank Statements showing the deposits, or IRS Form 1040, or IRS Form 1099
Profit from Self-Employment	IRS Form 1040 plus Schedule C
Rental Income, Royalty Income	IRS Form 1040, plus Schedule E for rental income
Interest or Dividends from Savings Accounts, Retirement Accounts, Stocks, Bonds	IRS Form 1040, or IRS Form 1099(s).
Insurance, Legal settlements	Settlement documents
Child and/or Spousal Support	Court Documents, or Copy of the Check
School Grants, Scholarships, or Other Aid	Award Letters, or two most recent consecutive Pay Stubs, or Copy of the Check
None of the Sources Above	A statement explaining the sources of income used to support your household

FOR INFORMATION ON CARE, CALL THE GAS COMPANYSM AT:

English: 1-800-427-2200
Korean 1-800-427-0471

Mandarin: 1-800-427-1429
Cantonese: 1-800-427-1420

Spanish: 1-800-342-4545
Vietnamese: 1-800-427-0478

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)

**SE REQUIERE
RESPUESTA INMEDIATA**

Apreciable cliente:

Fecha: 06/01/2009

Actualmente recibe una tarifa de descuento del 20% en su factura mensual de gas a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM. Su hogar fue seleccionado al azar para verificar que reúne los requisitos. Para continuar recibiendo este descuento, sírvase devolver el formulario debidamente llenado y firmado, junto con la documentación requerida en el sobre provisto en un término de 90 días. Si no responde o se determina que no reunía los requisitos, tal vez reciba facturas con los montos corregidos.

Documentación requerida: Sólo necesita proporcionar copias de la documentación de la lista 1 ó 2 (no ambas).

Lista 1) Si usted u otra persona que vive en su hogar recibe asistencia pública, sírvase enviar la documentación que compruebe su participación en cualquiera de los siguientes programas:

Medi-cal	Food Stamps	TANF(AFDC)	WIC	Healthy Families A&B	LIHEAP
----------	-------------	------------	-----	-------------------------	--------

ó

Lista 2) Si ningún miembro del hogar participa en alguno de los programas mencionados con anterioridad, sírvase enviar copias de los comprobantes de ingreso de cada miembro que viva en su hogar que reciba ingresos o alguna ayuda. El siguiente cuadro enlista las fuentes de ingreso y la documentación requerida:

Si recibe usted:	Documentación aceptable
Salarios, sueldos, propinas, comisiones	Los dos últimos talones de pago, W2, o formulario 1040 del IRS
Seguro social, SSI, SSDI, pensiones, pagos de incapacidad, indemnización para los trabajadores, beneficios de desempleo	Constancias de beneficios, copia del cheque, estados de cuenta bancarios que muestren los depósitos, formulario 1040 del IRS o formulario 1099 del IRS
Utilidades de autoempleo	Formulario 1040 del IRS y Anexo C
Ingresos por alquiler o regalías	Formulario 1040 del IRS y Anexo E para ingresos por alquiler
Intereses o dividendos de cuentas de ahorro, cuentas para el retiro, acciones, bonos	Formulario 1040 del IRS o formulario 1099(s) del IRS.
Pagos de reclamaciones legales y/o a seguros	Documentación relativa al pago de reclamaciones
Pensión alimenticia y/o conyugal	Documentación judicial o copia del cheque
Subvenciones, becas u otro tipo de ayuda escolar	Cartas de otorgamiento, los dos últimos talones de pago, o copia del cheque
Ninguna de las fuentes anteriores	Una declaración que explique las fuentes de ingreso usadas para mantener su hogar

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200
Coreano: 1-800-427-0471

Mandarín: 1-800-427-1429
Cantonés: 1-800-427-1420

Español: 1-800-342-4545
Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TTY): 1-800-252-0259 (disponible en inglés u español únicamente)



Semptra Energy utility

Verificación para la tarifa CARE del 20% de descuento

Form 6675-B (06/09) SP

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

(Por favor use tinta oscura y escriba claramente con letra de molde para asegurar el procesamiento apropiado)

Número de cuenta:

Fecha: 06/01/2009

Nombre del cliente:

Domicilio:

Teléfono de casa #: ■■■■ - ■■■■ - ■■■■ ■■

Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE. Si rellenó este círculo (●), por favor vaya directamente a la sección 4, **firmé** en la parte indicada, y envíe este formulario en el sobre con porte pagado adjunto en un término de 90 días.

(1) Número total de personas que viven en su hogar (inclúyase usted, otros adultos y niños): ■■

(2) Por favor enumere los nombres de todas las personas que viven en su hogar (inclúyase usted, adultos y niños) y rellene el círculo (●) para indicar si se trata de un adulto o un niño.

	Nombre	Adulto/Niño			Nombre	Adulto/Niño	
1.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	11.		<input type="radio"/>	<input type="radio"/>
6.		<input type="radio"/>	<input type="radio"/>	12.		<input type="radio"/>	<input type="radio"/>

Ingreso total anual en el hogar:

Si su hogar no participa en ninguno de los programas de asistencia de la **Lista 1**, sírvase rellenar el círculo (●) que corresponde al rango del ingreso anual de su hogar antes de deducciones.

\$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

Si es más de \$58,000, escriba el monto aquí: \$ ■■■■, ■■■■.00 al año

(3) **Incluí** copias de la documentación que prueba la participación en un programa de asistencia (lista 1) ó comprobantes de ingreso de cada miembro del hogar que recibe ingresos / ayuda (lista 2). Sírvase rellenar el círculo (●).

Sí No

(4) **DECLARACIÓN:** Por favor lea y firme abajo.

Declaro que la información y la documentación que proporcioné en este formulario de solicitud son verdaderas y correctas. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia con requisitos de ingreso.

Firma: X _____ Fecha: _____

PARA USO EXCLUSIVO DE SOCALGAS:

1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE

INC: \$ ■■■■ ■■■■

HH: ■■ ■■

INITIALS: ■■ ■■



親愛的客戶:

日期: 月/日/年

您現在正通過 **The Gas CompanySM** (瓦斯公司) 的加州能源優惠率 (**CARE**) 計劃, 享受占每月瓦斯 (煤氣) 帳單 **20%** 的 **CARE** 折扣優惠。您的家庭被隨機選中進行資格確認。若要繼續享受此項折扣, 請您將填寫好并簽名的表格以及所需文件放入所提供的信封中, 在 **90** 天內寄回。如果您沒有回復或經查證不符合資格, 您將會收到更正折扣的帳單。

所需文件: 您只需要提供列表1 或 列表2 中的文件副本, 而不需要提供所有兩個列表中的文件。

列表 1) 如果您或您家中的其他成員接受政府協助, 請您提供能够證明參與以下任何計劃的文件:

Medi-cal (加州醫療 輔助計劃)	Food Stamps (食物券)	TANF(AFDC) (貧困家庭臨時 現金資助計劃)	WIC (婦女, 嬰兒和兒 童營養輔助計劃)	Healthy Families A&B (健康家庭低費兒童醫 療健保計劃類別A及B)	LIHEAP (低收入家庭能源 協助計劃)
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列表 2) 如果您家中無人參加上述任何計劃, 請您提供您家中每位成員的收入文件副本, 包括所有收入和協助。以下表格列出了收入來源和所需文件:

如果您收到:	可以接受的文件:
工資, 薪金, 小費, 傭金	兩份最近連續的薪金支票存根(Pay Stubs), W2, 或 IRS 1040 表格
Social Security (社會安全福利金), SSI , SSDI (社會安全輔助金), 退休金, 殘疾津貼, 勞工補償, 失業救濟	福利說明書 (Statements of Benefits), 或支票副本, 或顯示存款數額的銀行月結單, 或 IRS 的 1040 或 1099 表格
自由業 (Self-Employment) 取得的利潤	IRS 的 1040 表格和 Schedule C 表格
租金, 權利金收入	IRS 的 1040 表格和租金收入使用的 Schedule E 表格
儲蓄賬戶, 退休賬戶, 股票和債券中取得的利息和紅利	IRS 的 1040 表格或 IRS 的 1099(s) 表格
保險賠償金和法律賠償金	處理結果文件
子女或配偶贍養費	法庭文件或支票副本
學校補助, 獎學金和其它助學金	獲獎信件, 兩份最近連續的補助金支票存根 (Pay Stubs), 或支票副本
其上來源都不是	一份解釋您用於支撐家庭的收入來源的證明

若需更多關於 CARE 計劃的諮詢, 請致電 THE GAS COMPANY

英語: 1-800-427-2200

國語: 1-800-427-1429

西班牙語: 1-800-342-4545

韓語: 1-800-427-0471

粵語: 1-800-427-1420

越南語: 1-800-427-0478

聽覺障礙專線 (TDD/TTY): 1-800-252-0259 (僅提供英語和西班牙語服務)



CARE 計劃 20% 費率折扣確認表格

(請用深色筆以正楷填寫清晰以確保適當受理)

Form 6675-B (06/09) CH

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

帳戶號碼:

日期: 06/01/2009

客戶姓名:

地址:

我不再符合或不願再參加 CARE 計劃。請把我的賬戶從 CARE 計劃中取消。如果您將這個圓圈塗黑(●), 請跳過 1 至 3 部分的内容, 在文件下方簽字, 將此表格放在所提供的郵資已付的信封中, 在 90 天內寄回。

(1) 您家庭中的總人數 (包括您本人, 其他成年人和兒童):

(2) 請列出您家庭中每位成員的姓名 (包括您本人, 其它成年人和兒童), 並將適當的圓圈塗黑(●)以顯示該成員是成人還是兒童。

姓名		成人/兒童		姓名		成人/兒童	
1.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	11.		<input type="radio"/>	<input type="radio"/>
6.		<input type="radio"/>	<input type="radio"/>	12.		<input type="radio"/>	<input type="radio"/>

家庭年收入總額:

如果您的家庭沒有參加列表 (1) 中的任何協助計劃, 請您把能體現您每年毛收入的圓圈塗黑(●)。

\$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

如果多於 \$58,000, 請在此處填寫金額: \$, .00 每年

聯絡電話 #: - -

(3) 我已經附上了能够證明參與協助計劃 (列表 1) 的文件副本或每個家庭成員的收入文件, 包括接受的所有收入和協助 (列表 2)。請塗黑符合您情況的圓圈(●)。

是 否

(4) 聲明: 請您閱讀並簽字。

我願意證明上述申請資料正確屬實。若需要我也同意提供文件證明符合 CARE 的資格。我同意若我不再符合條件時, 即通知 The Gas Company。我瞭解若不合格接受折扣, 我可能須退還我之前所接受的折扣。我瞭解 The Gas Company 可將有關我的資料提供給其他的公用事業公司和組織團體以協助我加入他們的協助計劃。

簽名: X 日期:

僅供 SOCALGAS 填寫:

1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE

INC: \$

HH:

INITIALS:



**즉시 회신하셔야
합니다**

친애하는 고객님:

날짜: YY년 MM월 DD일

귀하께서는 현재 The Gas CompanySM의 캘리포니아 에너지 대체 요금 (CARE) 프로그램을 통하여 월별 가스 요금에 대해 20% CARE 할인을 받고 계십니다. 귀 가구는 수혜 자격 확인 대상으로 무작위로 선정되었습니다. 이 할인을 계속 받으시려면, 작성하고 서명한 양식을 구비 서류와 함께 제공된 봉투를 사용하여 90일 내에 제출하십시오. 회답을 하지 않으시거나 자격이 없는 것으로 판단되면, 조정된 청구서를 받으실 수도 있습니다.

구비 서류: 목록 1 또는 2(두 목록 모두가 아님)의 문서의 사본을 제출하면 됩니다.

목록 1) 귀하나 기타 식구가 공공 지원을 받는 경우, 다음 중 해당 프로그램에 대한 참여를 입증하는 자료를 보내십시오.

Medi-cal	Food Stamps (푸드 스탬프)	TANF(AFDC)	WIC	Healthy Families A&B (건강한 가족 유형 A 및 B)	LIHEAP
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또는

목록 2) 식구 중 아무도 위에 언급된 어느 프로그램에도 참여하지 않는 경우, 소득이나 보조금을 받는 모든 식구에 대한 소득 서류 사본을 보내십시오. 아래 표는 소득원과 구비 서류를 나열합니다:

받는 소득:	인정되는 문서
임금, 봉급, 팁, 커미션	최근의 2 회 연속 보수 전표 또는 W2 또는 IRS 1040 양식
사회보장금, SSI, SSDI, 연금, 장애 지원금, 산재보상금, 실업수당	혜택 내역서 또는 수표 사본 또는 예금을 보여주는 은행 내역서 또는 IRS 양식 1040 또는 IRS 양식 1099
자영업 수익	IRS 양식 1040 과 스케줄 C
임대 소득, 로열티 소득	IRS 양식 1040 및 임대 소득에 대한 스케줄 E
예금 구좌, 은퇴 구좌, 주식, 채권의 이자나 배당금	IRS 양식 1040 또는 IRS 양식 1099.
보험, 법률 법적 타협금	타협 문서
어린이 및/또는 배우자 생활비	법원 문서 또는 수표 사본
학교 보조금, 장학금 또는 기타 보조금	수여 서신 또는 최근의 2 회 연속 보수 전표 또는 수표 사본
위의 소득원 해당되지 않음	가족 부양을 위해 사용된 소득의 원천을 설명하는 진술서

CARE 에 대한 사항은 아래의 THE GAS COMPANY 번호로 문의하십시오:

영어: 1-800-427-2200
한국어: 1-800-427-0471

북경어: 1-800-427-1429
광둥어: 1-800-427-1420

스페인어: 1-800-342-4545
월남어: 1-800-427-0478

청각 장애인(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)



CARE 20% 요금 할인 확인 양식

Form 6675-B (06/09) KO

(정확히 처리되도록 하기 위해 진한 펜을 사용하여 분명히 인쇄체로 기입하십시오)

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



구좌 번호:

날짜: 06/01/2009

고객 이름:

주소:

본인은 더 이상 자격이 없거나 CARE에 참여하기를 원치 않습니다. 본인의 구좌를 CARE 프로그램에서 삭제해 주십시오. 이 동그라미(●) 안을 채운 경우, 1~3 번을 생략하고 하단에 서명하여 이 양식을 제공된 우송료가 선불된 봉투에 넣어 90 일 내에 보내 주십시오.

(1) 귀 가구의 총 식구 수 (귀하, 다른 성인 및 어린이 포함):

(2) 모든 식구들(본인, 성인 및 어린이 포함)의 이름을 나열하고 각 식구가 성인인지 어린이인지를 해당 동그라미(●) 안을 채워서 표시하십시오.

이름		성인 / 어린이		이름		성인 / 어린이	
1.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	11.		<input type="radio"/>	<input type="radio"/>
6.		<input type="radio"/>	<input type="radio"/>	12.		<input type="radio"/>	<input type="radio"/>

총 연간 가구 소득: 공제하기 전에 귀 가구의 연간 총 소득 범위에 해당되는 동그라미(●) 안을 채우십시오.

\$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

\$58,000 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 \$, .00

주택 전화번호:

(3) 본인은 보조 프로그램(목록 1) 참여를 입증하는 문서 또는 소득 / 보조금(목록 2)을 받는 모든 식구에 대한 소득 문서의 사본을 포함하였습니다. 해당 동그라미(●)의 안을 채우십시오.

예

아니오

(4) 진술: 아래 사항을 읽고 서명하십시오.

본 신청서에서 본인이 제공한 정보와 문서가 정확한 사실임을 진술합니다. 본인이 할인을 받을 자격이 더 이상 없게 될 경우 The Gas Company에 통보하기로 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수도 있다는 것을 본인은 이해합니다. The Gas Company에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에 등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: X

날짜:

SOCALGAS에 한하여서만 사용 :

1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE

INC: \$

HH:

INITIALS:



Kính Gởi Quý Khách Hàng:

Ngày: MM/DD/YY

Quý vị hiện đang được giảm giá 20% theo chương trình CARE trên biên nhận gas hàng tháng qua chương trình Mức Giá Năng Lượng Thay Thế của California (California Alternate Rates for Energy hay CARE) của The Gas CompanySM. Hộ gia đình của quý vị được chọn ngẫu nhiên để xác minh tình trạng hội đủ điều kiện. Để tiếp tục được giảm giá theo chương trình này, xin gửi lại mẫu đơn đã điền đầy đủ và ký tên bao gồm cả (các) tài liệu được yêu cầu trong phong bì được cung cấp sẵn trong vòng 90 ngày. Nếu quý vị không hồi đáp hoặc cho thấy không hội đủ điều kiện, quý vị có thể nhận được biên nhận hiệu chỉnh.

Các Tài Liệu Yêu Cầu: Quý vị chỉ cần cung cấp bản sao của (các) tài liệu từ danh sách 1 **HOẶC** 2 (không phải cả hai)

Danh sách 1) Nếu quý vị hay người nào khác trong hộ gia đình được hưởng các chương trình trợ giúp công cộng, xin gửi tài liệu xác nhận được hưởng bất cứ chương trình nào sau đây:

Medi-cal	Food Stamps	TANF(AFDC)	WIC	Healthy Families A&B	LIHEAP
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HOẶC

Danh sách 2) Nếu không có ai trong hộ gia đình của quý vị được hưởng bất cứ chương trình nào ở trên, xin gửi bản sao các tài liệu về lợi tức của mọi thành viên trong hộ gia đình có lợi tức hoặc trợ cấp. Bảng dưới đây liệt kê các nguồn lợi tức và các tài liệu được yêu cầu:

Nếu quý vị nhận:	Các Tài Liệu Có Thể Chấp Nhận Được
Lương Tuần, Lương Tháng, Tiền Thưởng, Hoa Hồng	Hai Cùi Phiếu Lương liên tục gần đây nhất, hay mẫu đơn W2, hay mẫu đơn 1040 của IRS
An Sinh Xã Hội, SSI, SSDI, Hưu Bổng, Trợ Cấp Tàn Phế, Bồi Thường Lao Động, Trợ Cấp Thất Nghiệp	Bản Kê Trợ Cấp, hay Bản Sao Chi Phiếu, hoặc Bản Kê Trương Mục Ngân Hàng về khoản tiền gửi vào, hoặc Mẫu Đơn 1040 của IRS, hoặc Mẫu Đơn 1099 của IRS
Lợi Nhuận Khi Làm Việc Tự Do	Mẫu Đơn 1040 của IRS và Bản Liệt Kê C
Lợi Tức Cho Thuê, Lợi Tức Bản Quyền	Mẫu Đơn 1040 của IRS và Bản Liệt Kê E về lợi tức khi cho thuê
Lợi Tức hay Cổ Tức từ Trương Mục Tiết Kiệm, Hưu Trí, Cổ Phiếu, Trái Phiếu	Mẫu Đơn 1040 của IRS, hay (các) Mẫu Đơn 1099 của IRS
Bảo Hiểm, Bồi Thường Theo Pháp Luật	Tài Liệu về Bồi Thường
Tiền Nuôi Con và/hoặc Người Phối Ngẫu	Tài Liệu Toà Án, hay Bản Sao của Chi Phiếu
Tài Trợ Học Hành, Học Bổng, hay Trợ Giúp Khác	Thư Trao Tài Trợ, hoặc hai cùi phiếu lương liên tục gần đây nhất, hay Bản Sao của Chi Phiếu
Không có Nguồn Nào nêu Trên	Một bản kê giải thích các nguồn lợi tức dùng cho gia đình của quý vị

ĐỂ BIẾT THÊM THÔNG TIN VỀ CHƯƠNG TRÌNH CARE, XIN GỌI THE GAS COMPANY TẠI:

Tiếng Anh: 1-800-427-2200
Đại Hàn: 1-800-427-0471

Quan Thoại: 1-800-427-1429
Quảng Đông: 1-800-427-1420

Tây Ban Nha: 1-800-342-4545
Tiếng Việt: 1-800-427-0478

Số Máy dành cho Người Khiếm Thính (TDD/TTY): 1-800-252-0259 (chỉ có sẵn bằng tiếng Anh và tiếng Tây Ban Nha)



A Sempra Energy utility

Đơn Xác Minh Để Được Giảm Giá 20% Theo Chương Trình CARE

Form 6675-B (06/09) VI

THE GAS COMPANY
CARE PROGRAM ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

(Xin dùng mực đậm và viết bằng chữ in để đảm bảo xét duyệt chính xác)

Số Trương Mục:

Ngày: 06/01/2009

Tên Khách Hàng:

Địa chỉ:

- Tôi không còn hội đủ điều kiện hoặc không muốn tham gia vào chương trình CARE nữa. Xin rút trương mục của tôi ra khỏi chương trình CARE. Nếu quý vị bôi đen vào vòng tròn này (●), xin bỏ qua Phần 1 – 3, **ký tên** ở dưới, và gửi mẫu đơn này vào phong bì được cung cấp sẵn đã trả bưu phí trước trong vòng 90 ngày.

- (1) Tổng số người trong hộ gia đình của quý vị (bao gồm quý vị, những người lớn khác, và trẻ em):
- (2) Xin ghi tên mọi người trong hộ gia đình của quý vị (bao gồm quý vị, các người lớn, và trẻ em) và bôi đen vào vòng tròn (●) để cho biết mỗi người là người lớn hay là trẻ em.

Tên		Người Lớn/Trẻ Em		Tên		Người Lớn/Trẻ Em	
1.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	11.		<input type="radio"/>	<input type="radio"/>
6.		<input type="radio"/>	<input type="radio"/>	12.		<input type="radio"/>	<input type="radio"/>

Tổng Lợi Tức Hàng Năm của Hộ Gia Đình: Nếu gia đình của quý vị không được hưởng bất cứ chương trình trợ giúp nào ở **Danh Sách 1**, xin bôi đen vào vòng tròn (●) tổng mức lợi tức gộp hàng năm của quý vị.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000
- Nếu nhiều hơn \$58,000, xin điền tổng số vào đây: \$, .00 mỗi năm

Điện Thoại Nhà #: - -

- (3) Tôi đã **gởi kèm** các bản sao tài liệu chứng minh được hưởng một chương trình trợ giúp (danh sách 1) HOẶC (các) tài liệu về lợi tức cho mọi thành viên trong hộ gia đình có lợi tức/trợ cấp (danh sách 2).

Hãy bôi đen vào vòng tròn (●). Có Không

- (4) **Lời Khai: Xin đọc và ký tên bên dưới.**

Tôi xin khai rõ rằng thông tin mà tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý thông báo cho The Gas Company biết nếu tôi không còn hội đủ điều kiện để nhận giảm giá nữa. Tôi hiểu rằng nếu tôi được giảm giá khi không hội đủ điều kiện, tôi có thể được yêu cầu phải trả lại khoản giảm giá mà tôi đã nhận. Tôi hiểu rằng The Gas Company có thể chia sẻ thông tin của tôi với các hãng tiện ích khác hoặc các đại lý để ghi danh tôi vào các chương trình trợ giúp của họ.

Chữ ký: X

Ngày:

PHẦN DÀNH RIÊNG CHO SOCALGAS:

1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE

INC: \$

HH:

INITIALS:

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Submetered Residential (Form No. 6677-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 3988
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



A Sempra Energy utility

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY APPLICATION

The Gas Company's California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households.

To see if you qualify, check the requirements shown below. Please complete the application and return it in the envelope provided. Once your completed and signed application is approved by The Gas CompanySM, you will receive the CARE discount from your property owner/manager. You and your property owner/manager will be notified whether or not you are approved for the discount.

THERE ARE 2 WAYS TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or another person in your household receives benefits from any of the following programs:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2009 to May 31, 2010)</i>	
Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Each Additional household member, add	\$7,400

CONDITIONS FOR PARTICIPATION

- This address must be your primary residence.
- You must not be claimed as a dependent on another person's income tax return other than your spouse.
- You must recertify your application when requested.
- You must notify The Gas Company within 30 days if you no longer qualify.
- You may be asked to verify your eligibility for CARE.

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

- **DAP** - Direct Assistance Program, a low income energy efficiency program, offers free energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repair. 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.
- **LIHEAP** - Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Department of Community Services and Development at 1-866-675-6623.
- **California Lifeline (ULTS)** - A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English:	1-800-427-2200	Mandarin:	1-800-427-1429	Spanish:	1-800-342-4545
Korean:	1-800-427-0471	Cantonese:	1-800-427-1420	Vietnamese:	1-800-427-0478

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)



CARE 20% Rate Discount Application

(Please use dark ink and print clearly to ensure proper processing)

Form 6677-B (06/09) EN

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249



Facility ID:

Date: 06/01/2009

Customer Name:

Address:

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

↓
Home Phone #: - -

2A **Public Assistance Programs Benefits Received:**
If you or someone in your household receives benefits from any of the programs below, please fill in the circle (●), then SKIP **2B** and go directly to **3**.

- Medi-Cal: Under 65 of age Food Stamps Healthy Families A&B WIC
- Medi-Cal: 65 or older TANF (AFDC) LIHEAP

OR

*If NONE of the above, please complete section **2B**.*

2B **Household Income: Skip if you completed section **2A**.**
Part 1: If you do not participate in any of the programs listed above, please fill in the circle (●) for all sources of income in your household, and provide your total household income in the spaces provided below:

- Social Security Wages or Salaries Legal Settlements
- Pensions Unemployment Benefits Insurance Settlements
- SSI, SSP, SSDI Disability Payments Spousal Support
- Interest or Dividends from: Workers Compensation Child Support
- Savings Accounts, Pensions Scholarships, Grants, Cash and/or other income
- Stocks or Bonds or Other Aid Used for Rental or Royalty Income
- Retirement Accounts Living Expenses Profit from Self-Employment
(IRS Form 1040, Schedule C, line 29)

Part 2: Please fill in the circle (●) of your household's income range per year before deductions.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000

If more than \$58,000, enter amount here: \$, .00 per year

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 The Gas Company if I no longer qualify to receive the 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 The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs.

Signature: X

Date:

**FORMULARIO DE SOLICITUD PARA EL DESCUENTO CARE DEL 20%****SOLICITUD PARA EL PROGRAMA DE TARIFAS ALTERNAS PARA ENERGÍA EN CALIFORNIA**

El programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM ofrece un descuento del 20% en la factura mensual de gas a los hogares que reúnen los requisitos.

Para ver si califica, revise los requisitos que aparecen a continuación. Sírvase llenar el formulario de solicitud y regresarlo en el sobre provisto. Una vez que el formulario de solicitud debidamente llenado y firmado haya sido aprobado por The Gas Company, recibirá el descuento CARE del propietario / administrador de su vivienda. Se les notificará a usted y al propietario / administrador de su vivienda si se aprobó o no el descuento.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:
<p style="text-align: center;">Medi-Cal Food Stamps TANF(AFDC) Women, Infants & Children (WIC) Healthy Families Categories A&B LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)</p>

O

INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)</i>	
Número de personas en el hogar	Ingreso total anual
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Por cada miembro adicional en el hogar, añada	\$7,400

CONDICIONES PARA PARTICIPAR

- Esta dirección debe ser su domicilio principal.
- No debe aparecer como dependiente en la declaración de impuestos de otra persona que no sea su cónyuge.
- Debe recertificar que tiene derecho a CARE cuando se le solicite.
- Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- Tal vez se le pida comprobar que reúne los requisitos para CARE.

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE QUIZÁ PUDIERA CALIFICAR:

- **Programa de Asistencia Directa (DAP):** Este programa de eficiencia energética para clientes de bajos recursos ofrece mejoras gratuitas para el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a fin de ahorrar energía. Para más información, llame al 1-800-331-7593.
- **Asignación médica inicial (Medical Baseline):** Provee asignación adicional de gas a una tarifa menor a los clientes con ciertas afecciones. Para más información, llame al 1-800-342-4545.
- **Programa de Ayuda Energética para Hogares de Bajos Recursos (LIHEAP):** Ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y servicios de acondicionamiento contra las inclemencias del tiempo. Llame al Departamento de Servicios a la Comunidad de California al 1-866-675-6623.
- **Servicio Telefónico Universal Lifeline (California Lifeline-ULTS):** Acceso telefónico a precios de descuento para los clientes que reúnan requisitos de ingreso similares a los del programa CARE. Para más información, llame al proveedor de servicio telefónico de su localidad.

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200
Coreano: 1-800-427-0471

Mandarín: 1-800-427-1429
Cantonés: 1-800-427-1420

Español: 1-800-342-4545
Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)



Formulario de solicitud para la tarifa CARE del 20% de descuento

Form 6677-B (06/09) SP

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

(Por favor use tinta oscura y escriba claramente con letra de molde para asegurar el procesamiento apropiado)

Número de complejo habitacional:

Fecha: 06/01/2009

Nombre del cliente:

Domicilio:

1 Número total de personas que viven en su hogar (incluidos usted, otros adultos y niños):

Teléfono de casa: - -

2A **Beneficios que recibe a través de programas de asistencia pública:**
Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas demostrados, por favor rellene el círculo (●), y vaya directamente a la sección **3**.

- Medi-Cal: menor de 65 años Food Stamps Healthy Families A&B WIC
 Medi-Cal: 65 años o más TANF (AFDC) LIHEAP

O *Si no marcó NINGUNO, sírvase llenar la sección **2B**.*

Ingreso en el hogar: Sáteselo si llenó la sección **2A.**

2B **Parte 1:** Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el círculo (●) para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- | | | |
|--|--|---|
| <input type="radio"/> Seguro Social | <input type="radio"/> Salarios o sueldos | <input type="radio"/> Pagos de reclamaciones legales |
| <input type="radio"/> Pensiones | <input type="radio"/> Beneficios de desempleo | <input type="radio"/> Pagos de reclamaciones a seguros |
| <input type="radio"/> SSI, SSP, SSDI | <input type="radio"/> Pagos de incapacidad | <input type="radio"/> Pensión conyugal |
| Intereses o dividendos de: | <input type="radio"/> Indemnización para los trabajadores | <input type="radio"/> Pensión alimenticia |
| <input type="radio"/> Cuentas de ahorro, Pensiones | <input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida | <input type="radio"/> Dinero en efectivo y/u otros ingresos |
| <input type="radio"/> Acciones o bonos | | <input type="radio"/> Ingresos por alquiler o regalías |
| <input type="radio"/> Cuentas para el retiro | | <input type="radio"/> Utilidades de autoempleo (Formulario 1040, Anexo C, Renglón 29 del IRS) |

Parte 2: Sírvase rellenar el círculo (●) que corresponde al rango del ingreso anual de su hogar antes de deducciones.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000
 Si es más de \$58,000, escriba el monto aquí: \$, .00 al año

3 **Declaración:** Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en informar a The Gas Company si deajo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia con requisitos de ingreso.

Firma : X

Fecha:

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Submetered Residential (Form No. 6678-B, 06/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524



YOUR RATE DISCOUNT IS EXPIRING

Dear Customer:

Date: 06/01/2009

You are currently receiving a 20% rate discount on your monthly gas bill through The Gas Company's California Alternate Rates for Energy (CARE) program. In order to continue receiving the CARE discount from your property owner/manger, you are required to renew your eligibility within 90 days. To renew, use one of two methods listed below:

1. Return the completed and signed Certification Form in the envelope provided,
- OR**
2. Visit our Website <http://www.socalgas.com/care/recert/> and have your facility ID ready.

THERE ARE 2 WAYS TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or another person in your household receives benefits from any of the following programs:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2009 to May 31, 2010)</i>	
Number of Persons in Household	Total Annual Income
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Each Additional household member, add	\$7,400

CONDITIONS FOR PARTICIPATION

- This address must be your primary residence.
- You must not be claimed as a dependent on another person's income tax return other than your spouse.
- You must recertify your CARE eligibility when requested.
- You must notify The Gas CompanySM within 30 days if you no longer qualify.
- You may be asked to verify your eligibility for CARE.

FOR INFORMATION ON CARE, CALL THE GAS COMPANY AT:

English: 1-800-427-2200 Mandarin: 1-800-427-1429 Spanish: 1-800-342-4545
 Korean: 1-800-427-0471 Cantonese: 1-800-427-1420 Vietnamese: 1-800-427-0478

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)

Facility ID: 123 345 7890

**SU TARIFA DE DESCUENTO
ESTÁ POR VENCER**

Apreciable cliente:

Fecha: 06/01/2009

Actualmente recibe una tarifa de descuento del 20% en su factura mensual de gas a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas CompanySM. Con el fin de continuar recibiendo el descuento CARE del propietario / administrador de su vivienda, debe renovar su derecho a participar dentro de 90 días. Para renovarlo, use uno de los tres métodos que se enumeran a continuación:

1. Devuelva el Formulario de Recertificación debidamente llenado y firmado en el sobre provisto,

O

2. Visite nuestro sitio Web <http://www.socalgas.com/care/recert/> y tenga listo el número de complejo habitacional (*Facility ID*).

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO DE CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:
Medi-Cal
Food Stamps
TANF(AFDC)
Women, Infants & Children (WIC)
Healthy Families Categories A&B
LIHEAP (Programa de Asistencia de Energía para Hogares de Bajos Ingresos)

O

INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)</i>	
Número de personas en el hogar	Ingreso total anual
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000
Por cada miembro adicional en el hogar, añada	\$7,400

CONDICIONES PARA PARTICIPAR

- Esta dirección debe ser su domicilio principal.
- No debe aparecer como dependiente en la declaración de impuestos de otra persona que no sea su cónyuge.
- Debe recertificar su solicitud cuando se le solicite.
- Debe notificar a The Gas Company en un término de 30 días si deja de calificar.
- Tal vez se le pida comprobar que reúne los requisitos para CARE.

PARA INFORMACIÓN SOBRE CARE, LLAME A THE GAS COMPANY AL:

Inglés: 1-800-427-2200
Coreano: 1-800-427-0471

Mandarín: 1-800-427-1429
Cantonés: 1-800-427-1420

Español: 1-800-342-4545
Vietnamita: 1-800-427-0478

Para clientes con limitaciones auditivas (TDD/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

Número de complejo habitacional (*Facility ID*): 123 456 7890



Formulario de recertificación para la tarifa CARE del 20% de descuento

Form 6678-B (06/09) SP

THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

(Por favor use tinta oscura y escriba claramente con letra de molde para asegurar el procesamiento apropiado)

Número de complejo habitacional:

Fecha: 06/01/2009

Nombre del cliente:

Domicilio:

- Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE. Si rellenó este círculo (●), por favor sáltese las secciones 1 y 2, **firmo** en la parte de abajo, y envíe este formulario en el sobre con porte pagado provisto en un término de 90 días.

1 Número total de personas que viven en su hogar (incluidos usted, otros adultos y niños):

Teléfono de casa: - -

2A **Beneficios que recibe a través de programas de asistencia pública:**
Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas demostrados, por favor rellene el círculo (●), luego **SÁLTESE** la sección **2B** y pase directamente a la sección **3**.

- Medi-Cal: menor de 65 años
- Food Stamps
- Healthy Families A&B
- WIC
- Medi-Cal: 65 años o más
- TANF (AFDC)
- LIHEAP

Si no marcó NINGUNO, sírvase llenar la sección 2B.

2B **Ingreso en el hogar: Sáteselo si llenó la sección 2A.**
Parte 1: Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el círculo (●) para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- Seguro Social
- Pensiones
- SSI, SSP, SSDI
- Intereses o dividendos de:
 - Cuentas de ahorro, Pensiones
 - Acciones o bonos
 - Cuentas para el retiro
- Salarios o sueldos
- Beneficios de desempleo
- Pagos de incapacidad
- Indemnización para los trabajadores
- Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- Pagos de reclamaciones legales
- Pagos de reclamaciones a seguros
- Pensión conyugal
- Pensión alimenticia
- Dinero en efectivo y/u otros ingresos
- Ingresos por alquiler o regalías
- Utilidades de autoempleo (Formulario 1040, Anexo C, Renglón 29 del IRS)

Parte 2: Sírvase rellenar el círculo (●) que corresponde al rango del ingreso anual de su hogar antes de deducciones.

- \$0 - \$30,500
- \$30,501 - \$35,800
- \$35,801 - \$43,200
- \$43,201 - \$50,600
- \$50,601 - \$58,000

Si es más de \$58,000, escriba el monto aquí: \$, .00 al año

3 **Declaración:** Por favor lea y firme abajo.
Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia con requisitos de ingreso.

Firma : X

Fecha:

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM - BILL INSERT
(Form No. 6491-BI, 05/09)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 3988
DECISION NO.

1H9

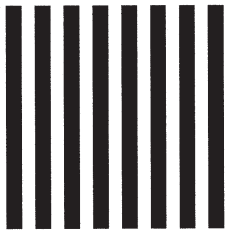
ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2009
EFFECTIVE Jun 1, 2009
RESOLUTION NO. E-3524

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



BUSINESS REPLY MAIL
FIRST-CLASS MAIL PERMIT NO. 11564 LOS ANGELES CA 90051

POSTAGE WILL BE PAID BY ADDRESSEE

**ATTN CARE PROGRAM ML GT12F1
THE GAS COMPANY
PO BOX 515005
LOS ANGELES CA 90099-9316**



A Sempra Energy utility®

SAVE 20%

**SEE IF YOUR HOUSEHOLD QUALIFIES.
IF YOU'RE RECENTLY UNEMPLOYED
YOU MAY ALSO BE ELIGIBLE.**

**VEA SI SU HOGAR CALIFICA.
SI SE ENCUENTRA USTED ACTUALMENTE
DESEMPLEADO USTED TAMBIÉN PUEDE
CALIFICAR PARA EL DESCUENTO.**

APPLY TODAY!

See inside for program details.

California Alternate Rates for Energy

(CARE) – 20% DISCOUNT
APPLICATION INSIDE OR APPLY AT
WWW.SOCALGAS.COM/ASSISTANCE/

Tarifas Alternas para Energía de California

(CARE) – DESCUENTO DEL 20%
EN SU TARIFA DE GAS NATURAL
SOLICITUD ADENTRO O APLICA EN
WWW.SOCALGAS.COM/SP/ASISTENCIA/

DEAR CUSTOMER:

You may be eligible for a 20% discount on your gas bill at your primary residence. You may also qualify for a \$15 discount on your Service Establishment Charge if you are approved within 90 days of starting new gas service with The Gas CompanySM. Please review the program qualifications on the enclosed application to see if you qualify. If you think you qualify, complete the application form and mail it back to us. You will receive your discount once your completed, signed application is approved by The Gas Company. If you have any questions about the CARE program, or need assistance filling out the form, please visit www.socalgas.com/assistance/ or call 1-800-427-2200. Telecommunication Devices for the Speech and Hearing Impaired (TDD) are available at 1-800-252-0259.

ESTIMADO(A) CLIENTE:

Usted podría ser elegible para recibir un 20% de descuento en su cuenta de gas de su residencia principal. También podría calificar para un descuento de \$15 en el Cargo por Establecimiento de Servicio, si usted es aprobado durante los primeros 90 días desde el comienzo de su nuevo servicio de gas con The Gas CompanySM. Por favor revise las calificaciones del programa en la solicitud. Si piensa que califica, complete y firme la solicitud y envíela a The Gas Company. Recibirá su(s) descuentos(s) una vez que su solicitud sea aprobada por The Gas Company. Si tiene alguna duda acerca de la solicitud, visite www.socalgas.com/sp/asistencia/ o llame 1-800-342-4545. Clientes con limitaciones auditivas (TDD) llamen al 1-800-252-0259.

FOR INFORMATION ON CARE IN OTHER LANGUAGES, CALL THE GAS COMPANY AT:

欲知詳情，請洽 免費國語專線: 1-800-427-1429

欲知詳情，請洽 免費粵語專線: 1-800-427-1420

더 자세한 안내를 받으시려면 다음 한국어 전화로 문의해 주십시오:
1-800-427-0471

Để biết thêm chi tiết bằng tiếng Việt, xin gọi:
1-800-427-0478

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

Direct Assistance Program (DAP): This low income energy efficiency program offers free, energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repairs. 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 Department of Community Services and Development at 1-866-675-6623.

California Lifeline (ULTS): A discounted telephone access for customers meeting similar income guidelines to CARE. For more information, contact your local telephone service provider.

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE PUEDE CALIFICAR:

Programa de Asistencia Directa (DAP): Este programa de eficiencia energética para clientes de bajos recursos ofrece mejoras gratuitas para el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a fin de ahorrar energía. Para más información, por favor llame al 1-800-331-7593.

Asignación Médica Inicial (Medical Baseline): Provee asignación adicional de gas a una tarifa menor a los clientes con ciertas afecciones médica. Para más información, llame al 1-800-342-4545.

Programa de Ayuda Energética para Hogares de Bajos Recursos (LIHEAP): Ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y servicios de acondicionamiento contra las inclemencias del tiempo. Llame al Departamento de Servicios a la Comunidad de California al 1-866-675-6623.

Servicio Telefónico Universal Lifeline (California Lifeline-ULTS): Acceso telefónico a precios de descuento para los clientes que reúnan requisitos de ingreso similares a los del programa CARE. Para más información, llame al proveedor de servicio telefónico de su localidad.

THERE ARE TWO WAYS TO QUALIFY / HAY DOS FORMAS DE CALIFICAR

1 PUBLIC ASSISTANCE PROGRAMS PROGRAMAS DE ASISTENCIA PÚBLICA

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

Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:

Medi-Cal

Food Stamps / Estampillas de Comida

TANF(AFDC)

Women, Infants & Children (WIC)

Healthy Families Categories A&B

LIHEAP

2 MAXIMUM HOUSEHOLD INCOME INGRESO MÁXIMO EN EL HOGAR:

(effective June 1, 2009 to May 31, 2010)

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)

Number of Persons in Household Número de personas en el hogar	Total Annual Income Ingreso total anual
1-2	\$30,500
3	\$35,800
4	\$43,200
5	\$50,600
6	\$58,000

For each additional household member, add \$7,400
Por cada miembro adicional en el hogar, añada \$7,400

CONDITIONS FOR PARTICIPATION / CONDICIONES PARA PARTICIPAR

1) The gas bill must be in your name and the address must be your primary address. / La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal. 2) You must not be claimed as a dependent on another person's income tax return other than your spouse. / No debe aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge.

3) You must recertify your application when requested. / Debe recertificar su solicitud cuando se le solicite. 4) You must notify The Gas Company within 30 days if you no longer qualify. / Debe notificar a The Gas Company en un término de 30 días si deja de calificar. 5) You may be asked to verify your eligibility for CARE. / Tal vez se le pida comprobar que reúne los requisitos para CARE.

FORM
9E

CARE APPLICATION / SOLICITUD PARA EL PROGRAMA CARE

PLEASE USE DARK BLUE OR BLACK INK ONLY / POR FAVOR USE TINTA AZUL OSCURA O NEGRA ÚNICAMENTE

ACCOUNT NO.
NO. DE CUENTA

Please provide your account number to expedite processing.
Por favor proporcione su número de cuenta para facilitar procesamiento.

FIRST NAME/NOMBRE

LAST NAME/APELLIDO

STREET NUMBER/NUMERO DE CALLE

STREET NAME/NOMBRE DE CALLE

APARTMENT/APARTAMENTO

CITY/CIUDAD

HOME PHONE/TELÉFONO DE SU CASA

1 Total number of persons in your household (include yourself, other adults, and children):
Número total de personas que viven en su hogar (inclúyase usted, otros adultos y niños):

2A

Public Assistance Programs Benefits Received / Beneficios que recibe a través de programas de asistencia pública:

If you or someone in your household receives benefits from any of the programs below, please fill in the circle(s) ●, and go directly to 3. Si usted, o alguien que vive en su hogar está recibiendo beneficios de uno de los programas siguientes, por favor rellene el/los círculo/s ●, y vaya directamente a la sección 3.

OR
Ó

- Medi-Cal: Under 65 years of age / menor de 65 años Food Stamps Healthy Families A&B WIC
 Medi-Cal: 65 years or older / 65 años o más TANF (AFDC) LIHEAP

If NONE of the above, please complete Section 2B / Si no marcó NINGUNO, sírvase llenar la sección 2B.

2B

Household Income Information / Ingreso anual de su hogar

Part 1 / Parte 1: If you do not participate in any of the programs listed above, please fill in the circle(s) ● for all sources of income in your household, and indicate your total household income in the spaces provided below: / Si no participa en ninguno de los programas que aparecen en la lista anterior, por favor rellene el/los círculo/s ● para todas las fuentes de ingreso en su hogar y proporcione el ingreso total de su hogar en los espacios que se proporcionan en la parte de abajo:

- Social Security / Seguro Social Spousal Support / Pensión conyugal
 Pensions / Pensiones Workers Compensation / Indemnización para los trabajadores
 SSI, SSP, SSDI Child Support / Pensión alimenticia
Interest or Dividends from / Intereses o dividendos de:
 Savings Accounts, Pensions / Cuentas de ahorro, pensiones Cash and/or other income / Dinero en efectivo y/u otros ingresos
 Stocks or Bonds / Acciones o bonos Scholarships, Grants, or Other Aid Used for Living Expenses / Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
 Retirement Accounts / Cuentas para el retiro
 Wages or Salaries / Salarios o sueldos Rental or Royalty Income / Ingresos por alquiler o regalías
 Legal Settlements / Pagos de reclamaciones legales Profit from Self-Employment, (IRS Form 1040, Schedule C, line 29) / Utilidades de autoempleo, (Formulario 1040, Anexo C, Renglón 29 del IRS)
 Unemployment Benefits / Beneficios de desempleo
 Insurance Settlements / Pagos de reclamaciones a seguros
 Disability Payments / Pagos de incapacidad

Part 2 / Parte 2: Please fill in the circle ● of your household's income range per year before deductions. / Sírvase rellenar el círculo ● de la gana que corresponde al ingreso anual de su hogar antes de deducciones.

- \$0 - \$30,500 \$30,501 - \$35,800 \$35,801 - \$43,200 \$43,201 - \$50,600 \$50,601 - \$58,000
 If more than \$58,000, enter the dollar amount here/Si es más de \$58,000, escriba el monto aquí: \$ _____, _____ .00 per year/al año

3 Declaration / Declaración: Please read and sign below / Por favor lea y firme abajo

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 The Gas Company 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 The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs. / Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar prueba de elegibilidad en el programa CARE si se me requiere. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en programas de asistencia.

SIGNATURE/
FIRMA

X

DATE/
FECHA

No Tape/No use cinta adhesiva

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No Staples/No engrape

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(Continued)

(TO BE INSERTED BY UTILITY)
 ADVICE LETTER NO. 3988
 DECISION NO.

ISSUED BY
Lee Schavrien
 Senior Vice President
 Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
 DATE FILED May 14, 2009
 EFFECTIVE Jun 1, 2009
 RESOLUTION NO. E-3524

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(Continued)

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