STATE OF CALIFORNIA

PUBLIC UTILITIES COMMISSION
505 VAN NESS AVENUE
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ARNOLD SCHWARZENEGGER, *Governor*

February 9, 2010

Advice Letter 4008

Ronald van der Leeden, Director
Rates, Revenues and Tariffs
555 W. Fifth Street, GT14D6
Los Angeles, CA 90013-1011

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

Dear Mr. van der Leeden:

Advice Letter 4008 is effective September 6, 2009.

Sincerely,

Julie A. Fitch, Director
Energy Division

Southern California Gas Company
A Sempra Energy utility®

Ronald van der Leeden
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Rates, Revenues, and Tariffs

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August 7, 2009

Advice No. 4008
(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' eligibility criteria for applicants by expanding the public assistance programs used to qualify residents or households for the CARE program as an alternative to the maximum household income-eligibility guidelines. This filing contains revisions to ten application forms: qualified agricultural employee housing; qualified nonprofit group living facilities; 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. This filing also revises the Application for CARE Program for Qualified Nonprofit Group Living Facilities (Form 6571-C).

Information

In compliance with Res. E-3524 and the notice dated April 28, 2009, from the Director of the Energy Division, SoCalGas filed Advice No. (AL) 3988 which revised SoCalGas' effective period for the income-qualified rate schedules that reflected the income-eligibility guidelines used to qualify individuals or households for the CARE program. The income guidelines remain unchanged. However, AL 3988 did not contain the complete list of the public assistance programs used to qualify residents or households for the CARE program as an alternative to the maximum household income-eligibility guidelines. This filing will now include the complete list of such public assistance programs. This filing will also revise Form 6571-C by re-organizing the eligibilities and requirements on the form for customers

to more easily determine their eligibility and understand the requirements. There is no change in the overall information presented on Form 6571-C from the previous form.

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 (jnj@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 2 (effective after staff approval) pursuant to GO 96-B. Therefore, SoCalGas respectfully requests that this advice letter become effective September 6, 2009, which is 30 calendar days after the date filed.

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
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EXPLANATION OF UTILITY TYPE
ELC = Electric GAS = Gas
PLC = Pipeline HEAT = Heat WATER = Water

(Date Filed/ Received Stamp by CPUC)

Advice Letter (AL) #: 4008

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 AL[1]: N/A

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

Resolution Required? ☐ Yes ☒ No

Tier Designation: ☐ 1 ☒ 2 ☐ 3

Requested effective date: September 6, 2009

No. of tariff sheets: 12

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 proposed[1]: N/A

Pending advice letters that revise the same tariff sheets: None

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:

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[1] Discuss in AL if more space is needed.

ATTACHMENT A

Advice No. 4008

(See Attached Service List)

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910 K STREET, SUITE 100
SACRAMENTO, CA 95814-3577

ATTACHMENT B
Advice No. 4008

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 44921-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY (CARE) PROGRAM FOR QUALIFIED , AGRICULTURAL EMPLOYEE HOUSING (Form 6632-C, 09/09)	Revised 44706-G
Revised 44922-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM FOR QUALIFIED NONPROFIT, GROUP LIVING FACILITIES (Form 6571-C)	Original 36230-G
Revised 44923-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - GENERAL PURPOSE, DIRECT MAIL (Form No. 6491-DM, 09/09)	Revised 44707-G
Revised 44924-G	SAMPLE FORMS: APPLICATIONS, Self-Certification CARE Application, Individually Metered Residential (Form No. 6491-C, 09/09)	Revised 44708-G
Revised 44925-G	SAMPLE FORMS: APPLICATIONS, Self-Recertification CARE Application, Individually Metered Residential (Form No. 6674-C, 09/09)	Revised 44709-G
Revised 44926-G	SAMPLE FORMS: APPLICATIONS, Capitation Program CARE Application, (Form No. 6491-2C, 09/09)	Revised 44710-G
Revised 44927-G	SAMPLE FORMS: APPLICATIONS, Post-Enrollment Verification CARE Application, Individually Metered Residential (Form No. 6675-C, 09/09)	Revised 44711-G
Revised 44928-G	SAMPLE FORMS: APPLICATIONS, Self-Certification CARE Application, Submetered Residential (Form No. 6677-C, 09/09)	Revised 44712-G
Revised 44929-G	SAMPLE FORMS: APPLICATIONS, Self-Recertification CARE Application, Submetered Residential (Form No. 6678-C, 09/09)	Revised 44713-G
Revised 44930-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - BILL INSERT, (Form No. 6491-BI, 09/09)	Revised 44714-G
Revised 44931-G	TABLE OF CONTENTS	Revised 44715-G
Revised 44932-G	TABLE OF CONTENTS	Revised 44897-G

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

(See Attached Form)

The Gas Company

A Sempra Energy utility℠

APPLICATION FOR 20% DISCOUNT
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:
Medicaid, Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC), TANF, Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, Food Stamps (SNAP), National School Lunch's Free Lunch Program (NSL), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME: *(effective June 1, 2009 to May 31, 2010)*	
Number of Persons in Household	Total Annual Income* *current household income from all sources before deductions
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.

The Gas Company

A Sempra Energy utility™

Application for 20% Discount
California Alternate Rates for Energy (CARE) Program
For Qualified Agricultural Employee Housing Facilities

If you have any questions: Call The Gas Company's CARE toll-free line at 1-800-207-8567, Monday through Friday, 7:00 a.m. to 4:00 p.m.

1 APPLICANT INFORMATION: (please type or print)

Name on Gas Bill _____

Name of Facility _____
(if different than on bill)

Account Number for This Facility ☐☐☐ ☐☐☐ ☐☐☐☐

Service Address _____ **City** _____, **CA Zip Code** _____

Mailing Address _____ **City** _____, **CA Zip Code** _____
(if different)

Facility Contact _____
(who to contact if utility needs more information)

E-mail Address _____
(optional)

Daytime Phone (☐☐☐)☐☐☐-☐☐☐☐ **Fax** (☐☐☐)☐☐☐-☐☐☐☐

2 FACILITY INFORMATION (check one)

☐ **EMPLOYEE HOUSING** (privately owned), as defined in Section 17008 of the Health and Safety Code, that is licensed and inspected in state and/or local agencies pursuant to part 1 of Division 13.

☐ **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 received exemptions from local property taxes pursuant to subdivision (g) of the Revenue and Taxation Code.

3 DECLARATION

By signing this application, I certify under penalty of perjury under the laws of the State of California that the information I have provided is true and accurate. I have:

- Verified the CARE eligibility of all residents of the facility and/or households meet CARE eligibility guidelines.
- Documentation is available to substantiate the above.
- Verified that each facility meets the residential energy usage criteria.

FOR ALL FACILITIES

Applicant is customer of record. Yes ☐ No ☐

100% of residents and/or households meet CARE eligibility guidelines. Yes ☐ No ☐

I have provided information on how the Discount for the coming year will be used to directly benefit the residents. Yes ☐ No ☐

FOR ALL FACILITIES (continued)

For recertification, I have provided information on how the discount was used for the direct benefit of the residents and I have documentation on file (if initial certification, leave blank). Yes ☐ No ☐

I understand the utility reserves the right to request documentation on the eligibility of the residents and the use of the discount. Yes ☐ No ☐

I understand the utility has the right to rebill me at the applicable rate if appropriate. Yes ☐ No ☐

I understand if the facility(ies), or the residents, become(s) ineligible to received the discount, I must notify the utility within 30 days. Yes ☐ No ☐

Last year's discount was used for _____
IF INITIAL CERTIFICATION, LEAVE BLANK

_____

This year's discount will be used for _____

_____

By signing this application, I give my consent that the information provided by me may be shared with other energy utility companies (limited to name and address).

_____
Authorized Representative's Name (please print or type)

_____
Authorized Representative's Title

_____
Authorized Representative's Signature

_____
Date

4 *FOR INDIVIDUAL FACILITIES OF THE SAME TYPE, ATTACH SEPARATE SHEET FOR MORE THAN FOUR (4) ADDRESSES:*

Account Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Service Address ______________________________ City ______________ CA Zip Code __________

Type of metering: ☐ Individually metered ☐ Master metered

Energy used for residential purpose: ☐100% ☐ At least 70%

Total number of residents (exclude on-site manager) ____________________________

100% of residents and/or households meet CARE eligibility criteria ☐ Yes ☐ No

---

Account Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Service Address ______________________________ City ______________ CA Zip Code __________

Type of metering: ☐ Individually metered ☐ Master metered

Energy used for residential purpose: ☐100% ☐ At least 70%

Total number of residents (exclude on-site manager) ____________________________

100% of residents and/or households meet CARE eligibility criteria ☐ Yes ☐ No

---

Account Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Service Address ______________________________ City ______________ CA Zip Code __________

Type of metering: ☐ Individually metered ☐ Master metered

Energy used for residential purpose: ☐100% ☐ At least 70%

Total number of residents (exclude on-site manager) ____________________________

100% of residents and/or households meet CARE eligibility criteria ☐ Yes ☐ No

---

Account Number: ☐☐☐ ☐☐☐ ☐☐☐☐

Service Address ______________________________ City ______________ CA Zip Code __________

Type of metering: ☐ Individually metered ☐ Master metered

Energy used for residential purpose: ☐100% ☐ At least 70%

Total number of residents (exclude on-site manager) ____________________________

100% of residents and/or households meet CARE eligibility criteria ☐ Yes ☐ No

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM FOR QUALIFIED NONPROFIT
GROUP LIVING FACILITIES (Form 6571-C) T

(See Attached Form)

Southern California Gas Company
A Sempra Energy utility®

Glad to be of service.®

Application for California Alternate Rates For Energy (CARE) Program

For Qualified Nonprofit Group Living Facilities

The CARE Program provides a 20% discount on the utility bill for facilities that meet program criteria established by the California Public Utilities Commission (CPUC). The discounted rate is available only to qualified facilities once the utility receives and approves the application.

INSTRUCTIONS

1. READ the information on page 2. If you have questions, call The Gas Company® CARE Department at 1-800-207-8567.

2. DETERMINE if the facility meets the definition of a qualified nonprofit group living facility. The facility MUST meet ALL criteria to qualify for the 20% discount.

3. COMPLETE the entire application (please print or type). Nonprofit corporations must complete this application for all qualified satellites.

4. ATTACH all required documents. (Application is not considered complete without documents.)

5. MAIL TO: **The Gas Company®**
CARE PROGRAM
SOUTHERN CALIFORNIA GAS COMPANY
PO BOX 515005 ML 12F1
LOS ANGELES CA 90099-9316

20% Discount

Terms and Conditions

California Alternate Rates for Energy (CARE) Program
For Qualified Nonprofit Group Living Facilities

Eligible Facilities

GROUP LIVING FACILITIES:

- Defined as transitional housing (such as drug rehabilitation or halfway houses), short-term or long-term care facilities (such as hospices, nursing home, children's or seniors' homes), group homes for physically or mentally challenged persons, or other nonprofit group living facilities.
- Corporation operating facility must have tax-exempt status under Internal Revenue Code Section 501 (c)(3).
- Facility must be licensed by the appropriate state agency, such as the State Department of Social Services.
- Facility must provide service, such as meals or rehabilitation, in addition to lodging.
- 100% of residents must meet current CARE eligibility guidelines for a single-person household (see enclosed Eligibility Guidelines).
- At least 70% of the natural gas used at the facility must be for residential purposes.

HOMELESS SHELTERS, WOMEN'S SHELTERS, & HOSPICES:

- Corporation operating facility must have tax-exempt status under Internal Revenue Code Section 501 (c)(3).
- Facility must have a Conditional Use Permit or provide adequate proof of eligibility.
- Facility must provide at least six (6) beds each day or night for a minimum of 180 days each year for persons who have no alternative residence.
- Primary function of facility must be to provide lodging.
- At least 70% of natural gas used at the facility must be for residential purposes.

SATELLITE FACILITIES:

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

Facilities Not Eligible

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

Application Requirements

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

Recertification

Facilities receiving the discount are required to recertify annually. To recertify, complete this application and provide:

- The amount of discount received in prior year, and
- An explanation of how the discount was used for the direct benefit of qualified residents.

CARE Department 1-800-207-8567 (English / Spanish)
Hearing Impaired (TDD/TTY) 1-800-252-0259 (English / Spanish)
FAX: 1-213-244-4665

Southern California Gas Company
A Sempra Energy utility

Glad to be of service.

Application for 20% Discount

California Alternate Rates for Energy (CARE) Program
For Qualified Nonprofit Group Living Facilities

Primary Facility Account Information:

Name on Gas Bill

Name of Facility (if different from name on gas bill)

Service Address | City | State

Mailing Address | City | State

Primary Contact

Phone | FAX

E-mail Address:

Account Number

Type of Facility:

☐ Group living facility:
Total Number of Residents at this Facility: _____ Total Number of Residents who are **qualified:** _____
(see Individual Eligibility Guidelines)

☐ Hospice ☐ Homeless Shelter or ☐ Women's Shelter:
Number of Beds: _____ Number of Days Occupied Each Year: _____

☐ Other: _____
Total Number of Residents at this Facility: _____ Total Number of Residents who are **qualified:** _____
(see Individual Eligibility Guidelines)

Primary Services Offered by Facility:

☐ Lodging ☐ Meals ☐ Rehabilitation ☐ Training ☐ Counseling
☐ Other: _____

Is at least 70% of the natural gas used at the facility for residential purposes?	Yes ☐	No ☐
Does nonprofit corporation operation facility have a tax-exempt status under Internal Revenue Section 501(c)(3)?	Yes ☐	No ☐
Is the facility government-owned or operated?	Yes ☐	No ☐

Name of Business License (Please attach a copy of the State-issued License or other adequate proof of eligibility for each facility)

Name on Conditional Use Permit (Please attach a copy of the Conditional Use Permit or other adequate proof of eligibility for each facility)

All Qualified Satellite Facilities (if applicable):

Facility Name

Service Address

Account Number - Satellite Facility? Yes ☐ No ☐

Group Living Facilities:	Total Number of Residents at this Facility:	Total Number of Residents who are **qualified** : (see Individual Eligibility Guidelines)
Hospice, Homeless Shelter, or Women's Shelter:	Number of Beds:	Number of Days Occupied Each Year:
Is at least 70% of the natural gas used at the facility for residential purposes?	Yes ☐	No ☐

(Continued on Back)

Southern California Gas Company

A Sempra Energy utility

Glad to be of service.®

Please complete the following information for all qualified satellite facilities:

Facility Name

Service Address

Account Number - | Satellite Facility? Yes No

Group Living Facilities: | Total Number of Residents at this Facility: | Total Number of Residents who are **qualified** : (see Individual Eligibility Guidelines)

Hospice, Homeless Shelter, or Women's Shelter: | Number of Beds: | Number of Days Occupied Each Year:

Is at least 70% of the natural gas used at the facility for residential purposes? Yes No

Facility Name

Service Address

Account Number - | Satellite Facility? Yes No

Group Living Facilities: | Total Number of Residents at this Facility: | Total Number of Residents who are **qualified** : (see Individual Eligibility Guidelines)

Hospice, Homeless Shelter, or Women's Shelter: | Number of Beds: | Number of Days Occupied Each Year:

Is at least 70% of the natural gas used at the facility for residential purposes? Yes No

Facility Name

Service Address

Account Number - | Satellite Facility? Yes No

Group Living Facilities: | Total Number of Residents at this Facility: | Total Number of Residents who are **qualified** : (see Individual Eligibility Guidelines)

Hospice, Homeless Shelter, or Women's Shelter: | Number of Beds: | Number of Days Occupied Each Year:

Is at least 70% of the natural gas used at the facility for residential purposes? Yes No

Certification of Eligibility:

Return to:

Southern California Gas Company
CARE Program, ML GT12F1
PO Box 515005
Los Angeles, California 90099-9316

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

Notice to customer: Signing this application allows The Gas Company to share your CARE information with other utilities, so that you may receive their discount, if applicable.

Authorized Representative's Name & Title (please print)

Authorized Representative's Signature | Date

Authorized Representative's Telephone Number

Southern California Gas Company
A Sempra Energy utility®

SOUTHERN CALIFORNIA GAS COMPANY
ENCLOSURE TO APPLICATION FOR
CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM
FOR QUALIFIED NONPROFIT GROUP LIVING FACILITIES

The California Alternate Rates for Energy (CARE) program provides a **20%** discounted rate on your gas bill.

PROGRAM QUALIFICATIONS

Each facility must meet all of the eligibility guidelines as shown on Southern California Gas Company Form Number 6571C and the CARE guidelines as shown below.

CARE QUALIFICATIONS

Individual Eligibility Guidelines

- Each resident's annual gross income does not exceed the amount shown OR receives benefits from any of the public assistance programs on the chart below.
- No resident can be claimed as a dependent on another person's State or Federal income tax form.

The following are the ways to qualify for the CARE discount:

The individual resident in facility receives benefits from any of the following programs:

Medicaid / Medi-Cal
Healthy Families A&B
Women, Infants, & Children (WIC)
TANFor Tribal TANF
Head Start Income Eligible - Tribal Only
Bureau of Indian Affairs General Assistance
Food Stamps (SNAP)
National School Lunch's Free Lunch Program (NSL)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

Total yearly income for each resident in the facility cannot be more than the following:

Number Of Persons	Total Yearly Individual Resident's Income In Facility Cannot Be More Than*
1-2	$30,500
3	$35,800
4	$43,200
5	$50,600

For Each Additional Person Add: $7,400

*** Effective date: June 1, 2009 to May 31, 2010**

WHAT COUNTS AS INCOME?

Total household income is all revenues, from all household members, from whatever sources derived, whether taxable or nontaxable, including, but not limited to: wages, salaries, interest, dividends, spousal and child support payments; public assistance payments, Social Security and pensions, rental income, income from self-employment, and all employment-related non-cash income.

If you have any questions, please call: 1-800-207-8567.

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

(See Attached Form)

The Gas Company

A Sempra Energy utility®

CARE

20% DISCOUNT

Dear Customer,

Through our California Alternate Rates for Energy (CARE) program, The Gas Company℠ 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/Medicaid
- Healthy Families Categories A & B
- Women, Infants, & Children (WIC)
- TANF or Tribal TANF
- Head Start Income Eligible – Tribal Only
- Bureau of Indian Affairs General Assistance (BIA GA)
- Food Stamps / SNAP
- National School Lunch's Free Lunch Program (NSL)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

←OR→

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	

* 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.

The Gas Company is committed to creating ways to help our customers manage their energy use and save money. If you have any questions or would like more information about our assistance programs, please visit *www.socalgas.com/assistance/* or call **1-800-427-2200**.

Sincerely,

Kirk Morales

Kirk Morales
CARE Program Sr. Market Advisor

The Gas Company

A Sempra 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: HOME PHONE: ☐☐☐ – ☐☐☐ – ☐☐☐☐

ACCOUNT #: EMAIL:

PLEASE COMPLETE IN BLACK OR DARK BLUE INK. CORRECT WAY TO MARK CIRCLES: ●

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

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

2 **Are you (or someone in your household) enrolled in any of the following assistance programs?**

○ **YES** (if yes, mark the program(s) of participation, and go to question **3**)

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **NO** (If no, please continue with the following questions)

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)?

○ $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

Please mark your sources of income:

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, Grants, or Other Aid used for Living Expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Declaration: Please read and sign below.

I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform 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: ☐☐/☐☐/☐☐

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 9 4

Printed on recycled paper with soy-based inks. FORM 6491-DM 0709 0990082 0909 XM

The Gas Company

A Sempra Energy utility®

CARE

20% DE DESCUENTO

Estimado Cliente:

Por medio de nuestro programa Tarifas Alternas para Energía de California (CARE), The Gas Company℠ 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 detras 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/Medicaid
- Familias Sanas Categorías A & B
- Programa de mujeres, infantes y niños (WIC)
- Asistencia temporal para familias necesitadas (TANF) o TANF tribal
- Elegible para ingreso de Ventaja Inicial – Solamente tribal
- Agencia de Asuntos Indios, Asistencia General (BIA GA)
- Programa de asistencia de nutrición suplementaria-cupones para alimentos/SNAP
- Programa de Almuerzo "National School Lunch's FREE" (NSL)
- Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- Ingreso Suplementario del Seguro Social (SSI)

←O→

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.

The Gas Company tiene el compromiso de crear maneras de ayudar a nuestros clientes manejar su uso de energía y ahorrar dinero. Si tiene preguntas o quisiera más información acerca de nuestros programas de asistencia, por favor visite *www.socalgas.com/sp/asistencia/* o llámenos al **1-800-342-4545**.

Atentamente,

Kirk Morales

Kirk Morales
Gerente del programa CARE

The Gas Company

A Sempra 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/ZIP: TELEFÓNO DE CASA: ☐☐☐ – ☐☐☐ – ☐☐☐☐

NO. DE CUENTA: CORREO ELECTRÓNICO:

POR FAVOR DE COMPLETAR EN TINTA NEGRA O AZUL OSCURA. FORMA CORRECTA DE MARCAR LOS CÍRCULOS: ●

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

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si mas de 6: ☐

2 ¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **SÍ** (Si su respuesta es afirmativa, marque el/los programa/s de participación, y vaya a la pregunta **3**)

- ○ Medi-cal / Medicaid: menor de 65 años
- ○ Medi-cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial - Solamente tribal

○ **NO**, (Si su respuesta es negativa, por favor continúe con las siguientes preguntas)

Si no está inscrito actualmente en ningún de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)?

○ $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

Por favor marque sus fuentes de ingreso:

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o indemnización para los trabajadores
- ○ Pension conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

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: ☐☐/☐☐/☐☐

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 9 2

Impreso en papel reciclado con tintas a base de soya. FORM 6491-DM 0709 0990082 0909 XM

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

(See Attached Form)

Form 6491-C EN (09/09)

20% DISCOUNT CARE 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. The discount will be applied once your completed and signed application is approved by The Gas Company[SM].

Please complete the application and return it in the envelope provided or apply online at http://www.socalgas.com/assistance

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:

If you or someone in your household participates in any of these programs:

Medicaid, Medi-Cal, Healthy Families A&B,
Women, Infants, & Children (WIC),
TANF, Tribal TANF,
Head Start Income Eligible - Tribal Only,
Bureau of Indian Affairs General Assistance,
Food Stamps (SNAP),
National School Lunch's Free Lunch Program (NSL),
Low Income Home Energy Assistance Program,
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2009 to May 31, 2010)
*current household income from all sources before deductions

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: Offers no-cost energy-saving home improvements such as ceiling insulation, doorweather-stripping, caulking and minor home repairs to eligible low-income home-owners and renters. For more information, please call 1-800-331-7593.

Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

LIHEAP: Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Dept. of Community Services and Development at 1-866-675-6623.

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

FOR MORE INFORMATION ON CUSTOMER ASSISTANCE:

English:	1-800-427-2200	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

Correct way to mark circles: ●

Form 6491-C EN (09/09)

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

A Sempra Energy utility®

1

Customer Name (as it appears on your bill):

Home Address (street, city, ZIP):

Account Number:

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐

E-mail Address:

2

Total # of adults and children in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

Are you (or someone in your household) enrolled in any of the following assistance programs?

○ **YES** *(If yes, mark the program(s) of participation, and go to question 3)*▼

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **NO** *(If No, please continue with following questions)*►

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)?▼

○ $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

Please mark your sources of income: ▼

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, grants, or other aid used for living expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Do you agree to the following? 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:** ☐☐ / ☐☐ / ☐☐

Form 6491-C SP (09/09)

FORMULARIO DE SOLICITUD PARA EL DESCUENTO CARE DEL 20%

EL PROGRAMA DE TARIFAS ALTERNAS PARA ENERGÍA EN CALIFORNIA

El programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company 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 nuevo servicio de gas también recibirán un descuento de $15 en el Cargo de Conexión de Servicio (*Service Establishment Charge*). El descuento se aplicará una vez que el formulario de solicitud debidamente llenado y firmado haya sido aprobado por The Gas Company[SM].

Sírvase llenar el formulario de solicitud y regresarlo en el sobre provisto, o presentarlo en línea en www.socalgas.com/sp/asistencia

CÓMO CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:

Si usted o alguien que vive en su hogar participa en cualquiera de estos programas:

Medicaid/Medi-Cal, Familias Sanas Categorías A & B,
Programa para Mujeres, Infantes, y Niños (WIC),
Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal,
Cupones para alimentos / SNAP
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa de Almuerzo "National School Lunch's FREE" (NSL)
Agencia de Asuntos Indios, Asistencia General (BIA GA)
Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

O

INGRESO MÁXIMO EN EL HOGAR:*

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

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 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 TAL VEZ CALIFIQUE:

DAP: El Programa de Asistencia Directa, un programa de eficiencia energética para clientes de bajos recursos, ofrece mejoras gratuitas que ahorran energía en el hogar, tales como aislamiento de techo, colocación de burletes para puertas, enmasillado y reparaciones menores a la casa. 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.

LIHEAP: El Programa de Ayuda Energética para Hogares de Bajos Recursos ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y protección de la casa contra los agentes atmosféricos. Llame al Departamento de Servicios a la Comunidad al 1-866-675-6623.

California Lifeline: 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 MÁS INFORMACIÓN ACERCA DE ASISTENCIA AL CLIENTE:

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/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

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

Form 6491-C SP (09/09)

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

A Sempra Energy utility

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

Forma correcta de marcar los círculos: ●

1

Nombre del cliente (tal como aparece en su factura):

Domicilio particular:

Número de cuenta:

Teléfono: ( ) -

Dirección de correo electrónico:

2

Número total de adultos y niños que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6:

¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **Sí** *(Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3)* ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes, y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

○ **No** *(Si su respuesta es negativa, por favor continúe con las siguientes preguntas)*►

Si no está inscrito actualmente en ninguno de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

○ $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

Por favor marque sus fuentes de ingreso: ▼

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o Indemnización para los trabajadores
- ○ Pensión conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

3

¿Acepta usted lo siguiente? Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar comprobantes de elegibilidad para CARE si se me solicita. 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** : / /

Form 6491-C CH (09/09)

20% CARE
折扣申請表

加州能源優惠計劃申請

The Gas Company 的加州能源優惠 (CARE) 計劃向符合特定資格的家庭提供 20% 的瓦斯（煤氣）費折扣。 如果您在新開瓦斯服務的 90 天之內申請並通過審核，還可獲得 $15 的開戶手續費優惠。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：

Medicaid / Medi-Cal (加州醫療輔助計劃)、 Healthy Families A&B(健康家庭低費兒童醫療健保計劃類別 A 及 B)、 Women, Infants & Children (WIC, 婦女,嬰兒和兒童營養輔助計劃)、 TANF(貧困家庭臨時現金資助計劃)、部落 TANF、 Head Start Income Eligible (學前教育班補助金計劃, 僅限於部落)、 Bureau of Indian Affairs General Assistance (印第安事務局一般協助計劃)、Food Stamps(SNAP,食物券)、 National School Lunch's Free Lunch Program(NSL, 全國學童免費午餐計劃)、 Low Income Home Energy Assistance Program (LIHEAP, 低收入家庭能源協助計劃)、Supplemental Security Income (SSI, 社會安全輔助金)

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）
*包括所有來源的家庭現有稅前收入

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（國語）/1-800-427-1420（粵語）。

Medical Baseline（醫療基綫計劃）： 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（國語）/1-800-427-1420（粵語）。

LIHEAP（低收入家庭能源協助計劃）： 提供帳單付費協助,緊急帳單協助和增强禦寒性能服務。請致電 California Dept. of Community Services and Development（加州社區服務與發展部）1-866-675-6623。

California Lifeline（加州普濟電話服務計劃）： 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。

若需更多資訊，請致電我們的客戶服務：

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
聽覺障礙專綫 (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

正確涂圈方法：●

Form 6491-C CH (09/09)

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

1

客戶姓名：

地址：

帳戶號碼：

聯絡電話：(□□□)□□□-□□□□

電郵地址：

2

您家庭中的總人數： ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 如果超過 6: □

您（或您的家人）是否有人參加了以下協助計劃？

○ 是 *（請把您或您家人所接受福利的計劃前塗黑，然後直接到問題 3）*▼

- ○ 加州醫療輔助計劃: 低于 65 歲
- ○ 加州醫療輔助計劃: 65 歲或更大年齡
- ○ 健康家庭低費兒童醫療健保計劃類別 A 及 B
- ○ WIC - 婦女，嬰兒和兒童營養輔助計劃
- ○ TANF（貧困家庭臨時現金資助計劃）或 部落 TANF
- ○ 食物券 / SNAP
- ○ LIHEAP 低收入家庭能源協助計劃
- ○ 社會安全輔助金 (SSI)
- ○ 全國學童免費午餐計劃 (NSL)
- ○ 印第安事務局一般援助
- ○ 學前教育班補助金計劃（僅限於部落）

○ 否 *（如果回答為否，請繼續以下問題）*►

如果您沒有參加以上任何計劃，請按照您的家庭年收入（税前收入，包括所有家庭成員），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

○ 如果多于 $58,000，請在此處填寫金額：$□□,□□□.00 每年

請把您家庭收入所有來源前面的圓圈塗黑：▼

- ○ 社會安全福利金 Social Security
- ○ 社會安全輔助金 SSP, SSDI
- ○ 退休金
- ○ 從以下項目獲取的利息或紅利:儲蓄賬戶、股票、債券，或退休賬戶
- ○ 工資或薪金
- ○ 失業救濟金
- ○ 保險或法律賠償
- ○ 殘疾津貼或勞工補償
- ○ 配偶或子女支付的贍養費
- ○ 獎學金, 助學金, 或其它用于支付生活費用的助學津貼
- ○ 租金或權利金收入
- ○ 現金或其它收入

3

您同意以下聲明嗎？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它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：**□□ / □□ / □□

Form 6491-C KO (09/09)

20% CARE 할인 신청서

A Sempra Energy utility®

캘리포니아 에너지 대체 요금 신청서

The Gas Company 의 캘리포니아 에너지 대체 요금(CARE) 프로그램은 적격 가구의 월별 가스 요금에 대해 20% 할인을 제공합니다. 자격을 갖추고 또한 가스 서비스를 새로 시작한 후 90 일 내에 승인을 받은 사람은 가스 개설료에 대해 $15 할인을 받습니다. 귀하의 작성되고 서명된 신청서를 The Gas Company[SM] 에서 승인하면 할인이 적용될 것입니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:

귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:

메디케이드 (Medicaid) , Medi-Cal,
건강한 가족 유형 A 및 B (Healthy Families A&B),
여성, 유아 및 어린이 (WIC),
TANF 또는 부족 TANF,
헤드 스타트 소득 자격 (Head Start - Income Eligible) (인디언 부족만 해당),
인디언 업무 일반 보조국(Bureau of Indian Affairs General Assistance),
푸드 스탬프 (Food Stamps, SNAP),
학교 무료 점심 프로그램 (National School Lunch's Free Lunch Program),
저소득 주택 에너지 지원 프로그램 (LIHEAP),
추가 사회보장 수입 (SSI)

또는

최대 가구 소득*:
(2009. 6. 1 부터 2010. 5. 31 까지 유효)
*세액 공제전 가구의 현재 총소득

가구의 식구 수	총 연간 소득
1-2	$30,500
3	$35,800
4	$43,200
5	$50,600
6	$58,000
추가되는 식구 1 인당 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 30 일 이내에 The Gas Company 에 통보해야 합니다. / CARE 에 대한 수혜자격을 입증하도록 요청 받을 수 있습니다.

수혜 대상이 가능한 기타 프로그램과 서비스:

DAP – 저소득자 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 – 저소득자 주택 에너지 지원 프로그램인 LIHEAP 는 청구금액 지원, 긴급 요금 지원 및 내후 단열 서비스를 제공합니다. 1-866-675-6623 번의 캘리포니아 지역사회 서비스 개발부로 문의하십시오.

California Lifeline (캘리포니아 라이프라인) – CARE 와 유사한 소득 기준을 충족시키는 고객들을 위한 할인 전화 이용. 자세한 내용은 현지의 전화회사에 문의하십시오.

고객 지원에 대한 추가 사항은 다음 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
동그라미에 바르게 표시하는 방법: ●

Form 6491-C KO (09/09)

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

1

고객 이름:

주소:

구좌 번호:

주택 전화번호: (□□□)□□□-□□□□

이메일 주소:

2

귀 가구의 총 식구 수: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 만약 6 개 이상: □

귀하 (또는 식구 중 누군가)는 다음 보조 프로그램에 등록되었습니까?

○ **예** *(예인 경우 참여 프로그램에 표시하고 3 번 질문으로 가십시오.)*▼

- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 미만
- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 이상
- ○ 가정 건강 유형 (Healthy Families Categories) A & B
- ○ 여성, 유아 및 어린이 프로그램(WIC)
- ○ 불우 가정 임시 보조(TANF) 또는 인디언 부족 TANF
- ○ 푸드 스탬프(Food Stamps) / SNAP
- ○ 저소득자 주택 에너지 지원 프로그램인 (LIHEAP)
- ○ 보조 사회보장 수입 (SSI)
- ○ 학교 무료 점심 프로그램(National School Lunch's FREE Lunch Program)
- ○ 인디언 업무 일반 보조국(Bureau of Indian Affairs General Assistance)
- ○ 헤드 스타트 소득 자격(Head Start Income Eligible) (인디언 부족만 해당)

○ **아니오** *(아니오인 경우 다음 질문사항을 계속하십시오)*▼

위에 나열된 어느 프로그램에도 등록되지 않으신 경우, 귀하의 연간 소득은 얼마입니까 (공제전, 모든 가족의 소득 포함)?►

○ $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

귀하의 소득원에 표시하십시오: ▼

- ○ 사회보장금
- ○ SSI 또는 SSDI
- ○ 연금
- ○ 저축, 주식, 채권, 또는 은퇴 구좌로 부터의 이자 또는 배당금
- ○ 임금 그리고/또는 자영업 수익
- ○ 실업 혜택
- ○ 보험금 또는 법적 타협금
- ○ 장애 또는 산재 보상금
- ○ 배우자 또는 자녀 부양비
- ○ 장학금, 수여금, 또는 기타 생활 보조금
- ○ 임대료나 로열티 소득
- ○ 현금 또는 기타 소득

3

다음 사항에 동의하십니까? 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:** □□ / □□ / □□

Form 6491-C VI (09/09)

ĐƠN XIN GIẢM GIÁ

A Sempra Energy utility®

ĐƠN XIN HƯỞNG MỨC GIÁ NĂNG LƯỢNG THAY THẾ CỦA CALIFORNIA

Chương Trình Mức Giá Năng Lượng Thay Thế California (California Alternate Rates for Energy hay CARE) của The Gas Company giảm giá 20% trên biên nhận gas hàng tháng cho các 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). Sẽ áp dụng giảm giá khi đơn xin đã điền đầy đủ và ký tên của quý vị được The Gas Company[SM] chấp thuận.

CÁCH 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 gia đình nhận trợ cấp từ bất cứ chương trình nào sau đây:
Medicaid, Medi-Cal,
Gia đình Khỏe mạnh loại A&B,
Phụ nữ, Sơ sinh, & Trẻ em (WIC),
TANF, Bản địa TANF,
Chương trình Mầm non cho người có Lợi tức Hợp lệ (Chỉ dành cho Bản địa),
Hỗ trợ Tổng quát của Văn phòng Sự vụ Da Đỏ (Bureau of Indian Affairs General Assistance),
Food Stamps (SNAP),
Chương trình Toàn quốc ăn Trưa Miễn phí tại Trường (NSL),
Chương trình Trợ giúp Năng lượng cho Gia đình có Lợi tức Thấp (LIHEAP),
Trợ Giúp An sinh Xã hội (SSI)

HOẶC

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH*:
(hiệu lực từ ngày 1 tháng Sáu, 2009 đến 31 tháng Năm, 2010)
*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình

Số Người trong 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 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 The Gas Company trong vòng 30 ngày nếu không còn hội đủ điều kiện nữa. / Quý vị có thể bị kiểm 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 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 Dept. of Community Services and Development (Sở Dịch Vụ Cộng Đồng và Phát Triển California) tại số 1-866-675-6623.

California Lifeline - 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 TRỢ GIÚP KHÁCH HÀNG:

Tiếng Anh: 1-800-427-2200 Quan Thoại: 1-800-427-1429 Tây Ban Nha: 1-800-342-4545
Tiếng 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 bằng tiếng Anh và 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
Bôi đen đúng cách: ●

A Sempra Energy utility®

Form 6491-C VI (09/09)

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

1

Tên Khách Hàng:

Địa chỉ:

Số Trương Mục:

Điện Thoại Nhà #: (☐☐☐)☐☐☐-☐☐☐☐

Địa chỉ E-mail:

2

Tổng số người trong hộ gia đình của quý vị: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ nếu có nhiều hơn 6: ☐

Quý vị (hoặc ai đó trong gia đình quý vị) có được hưởng bất cứ chương trình trợ giúp nào sau đây không?

○ **CÓ** *(Nếu có, xin bôi đen vào vòng tròn của (các) chương trình được hưởng, rồi chuyển sang câu 3)*▼

- ○ Medi-Cal: Dưới 65 tuổi
- ○ Medi-Cal: 65 tuổi
- ○ Gia Đình Khỏe Mạnh Loại A & B Chương Trình Phụ Nữ, Sơ Sinh và Trẻ Em (WIC)
- ○ Trợ Giúp Tạm Thời cho G Đnh có Nhu Câu (TANF) hoặc TANF Bản Địa
- ○ Phiếu Thực Phẩm
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Tribal Only

○ **KHÔNG** *(Nếu không, xin tiếp tục các câu sau)*►

Nếu quý vị không được hưởng bất cứ chương trình nào ở trên, mức lợi tức hàng năm của gia đình quý vị là bao nhiêu (lợi tức trước khi khấu trừ, bao gồm tất cả mọi người trong gia đình)? ▼

○ $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

Xin bôi đen vào vòng tròn của các nguồn lợi tức của quý vị: ▼

- ○ An sinh Xã hội
- ○ SSP, SSDI
- ○ Hưu bổng
- ○ Tiền Lời hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí
- ○ Lương và/hoặc Lợi tức Viêc Làm Tự do
- ○ Trợ cấp Thất nghiệp
- ○ Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định
- ○ Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm
- ○ Cấp dưỡng nuôi Con hoặc Phối ngẫu
- ○ Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống
- ○ Lợi tức cho Thuê hoặc Tiền Bản quyền
- ○ Lợi tức Tiền mặt hoặc Lợi tức Khác)

3

Quý vị có đồng ý với điều sau đây không? 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 cớ về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý 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 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:** ☐☐ / ☐☐ / ☐☐

Form 6491-C ARA (9/09)

طلب تخفيض
%20

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 المؤهلين والذين تمت الموافقة عليهم خلال 90 يوماً من بدء خدمة غاز جديدة تخفيضاً قدره 15 دولاراً من تكلفة تأسيس الخدمة. سيتم البدء في تطبيق التخفيض بعد أن توافق The Gas Company℠ على طلبك الموقع.

يرجى ملئ الطلب وإعادته في الظرف المرفق أو التقدم بطلب على الإنترنت بالعنوان التالي
http://www.socalgas.com/assistance/care/

كيف تتأهل للحصول على تخفيض CARE

الحد الأعلى لدخل العائلة*:
(ساري المفعول من 1 يونيو 2009 إلى 31 مايو 2010)
* دخل العائلة الجاري من جميع المصادر قبل الحسم

عدد أفراد العائلة	الدخل السنوي الإجمالي
2-1	30500 دولار
3	35800 دولار
4	43200 دولار
5	50600 دولار
6	58000 دولار
لكل فرد إضافي في العائلة، أضف	7400 دولار

أو

برامج المساعدة الحكومية:

إذا كنت أنت أو أي من أفراد أسرتك تتلقون معونات من أي من البرامج التالية:

Medicaid, Medi-Cal, Healthy Families A&B,
Women, Infants, & Children (WIC),
TANF, Tribal TANF,
Head Start Income Eligible - Tribal Only,
Bureau of Indian Affairs General Assistance,
Food Stamps (SNAP),
National School Lunch's Free Lunch Program (NSL),
Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

شروط الاشتراك

يجب أن تكون فاتورة الغاز باسمك وأن يكون العنوان على الفاتورة هو عنوانك الرئيسي. / يجب ألا تكون مدرجا كشخص عالة على غيرك على استمارة الضريبة باستثناء زوجك أو زوجتك. / يجب أن تصحح المعلومات على طلب التخفيض عندما يُطلب منك ذلك. / عليك إبلاغ The Gas Company خلال 30 يوما إذا فقدت تأهلك لهذا البرنامج. / قد يُطلب منك إثبات تأهلك للمشاركة في برنامج CARE.

قد تتأهل لبرامج أو خدمات أخرى:

- **DAP** – Direct Assistance Program، برنامج فعالية الطاقة لذوي الدخل المحدود. يقدم تحسينات منزلية مجانية لتوفير الطاقة مثل عزل السقف، وضع شرائط عزل حول الأبواب، إملاء الفراغات وإصلاحات ثانوية للمنزل. لمزيد من المعلومات، يرجى الاتصال بالرقم 1-800-331-7593.
- **Medical Baseline** – يوفر حصة إضافية من الغاز بسعر أرخص للعملاء ذو الاحتياجات الطبية الخاصة. لمزيد من المعلومات. اتصل بالرقم 1-800-427-2200

LIHEAP – Low Income Home Energy Assistance Program، ويقدم مساعدة في دفع الفاتورة ومساعدة طارئة في دفع الفاتورة وخدمات مقاومة العوامل الجوية. اتصل بـ California Department of Community Services and Development على الرقم: 1-866-675-6623.

California Lifeline – 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

Form 6491-C ARA (9/09)

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

طلب تخفيض 20% خاص ببرنامج CARE

يُرجى استخدام حبر غامق والكتابة بخط واضح حتى تتم دراسة الطلب بالشكل الصحيح

الطريقة الصحيحة لتعليم الدوائر: ●

1

اسم العميل
(كما يظهر على الفاتورة)

العنوان
(اسم الشارع والمدينة والرمز البريدي)

رقم الحساب

رقم الهاتف

البريد الإلكتروني

2

عدد الأفراد البالغين والأطفال في عائلتك

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

هل تشارك أنت (أو شخص آخر في عائلتك) في أي واحد من البرامج التالية؟

○ **نعم** *(إذا أجبت نعم ضع علامة أمام البرنامج أو البرامج التي تشارك فيها ثم انتقل إلى السؤال 3)*◄

- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible– قبلي فقط
- ○ Medi-Cal / Medicaid: أقل من 65 سنة
- ○ Medi-Cal / Medicaid: 65 سنة أو أكثر
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP

○ **لا** *(إذا أجبت لا، الرجاء الإجابة على الأسئلة التالية)* ◄

إذا لم تكن مشتركا في أحد البرامج المدرجة أعلاه ، يُرجى ذكر دخل العائلة السنوي (قبل الخصومات بما فيه جميع أفراد العائلة)؟▼

○ 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 , في السنة

الرجاء وضع علامة أمام مصدر أو مصادر دخلك:▼

- ○ نفقة زوجية أو نفقة طفل
- ○ منح أو منح مدرسية أو منح أخرى تُستعمل لنفقات العيش
- ○ إيجار أو علاوات
- ○ نقد أو مصدر دخل آخر
- ○ المرتبات والأجور و/أو أرباح من عمل حر
- ○ تعويضات العاطلين عن العمل
- ○ تسويات قانونية أو تأمين
- ○ تعويضات عجز (إعاقة) أو تعويضات العاملين
- ○ Social Security
- ○ SSP أو SSDI
- ○ معاش
- ○ فوائد أو أرباح من: حسابات ادخار أو أسهم أو سندات أو حسابات تقاعد

3

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

التوقيع **X** التاريخ / /

20% CARE
ԶԵՂՉԻ ԴԻՄՈՒՄ

A Sempra Energy utility®

The Gas Company-ի California Alternate Rates for Energy (CARE) (Կալիֆորնիայի Այլընտրանքային Գները Էներգիայի համար) պայմանունակ ընտանիքներին ծրագիրը մատակարարում է ամսական 20% զեղչ գազի հաշվի համար: Նրանք, ովքեր որակավորված են և վավերացված՝ գազի նոր ծառայությունը սկսելուց 90 օրվա ընթացքում, կստանան նաև $15 զեղչ Ծառայության Հաստատման Ծախքի համար: Զեղչը կկիրառվի, երբ որ լրացնեք և ստորագրված դիմումը վավերացվի The Gas Company℠-ի կողմից:

Խնդրվում է լրացնել դիմումը և ներդրված ծրարով վերադարձնել կամ դիմել առցանց՝
http://www.socalgas.com/assistance/care/

ԻՆՉՊԵՍ ՊԱՅՄԱՆՈՒՆԱԿ ԴԱՌՆԱԼ ԶԵՂՉԻՆ.

ՀԱՍԱՐԱԿԱԿԱՆ ՕԳՆՈՒԹՅԱՆ ԾՐԱԳՐԵՐԸ՝

Եթե դուք կամ ձեր ընտանիքից ուրիշ անդամ օգտվում եք հետևյալ ծրագրերից որևէ մեկից

Medicaid, Medi-Cal, Healthy Families A&B,
Women, Infants, & Children (WIC),
TANF, Tribal TANF,
Head Start Income Eligible - Tribal Only,
Bureau of Indian Affairs General Assistance,
Food Stamps (SNAP),
National School Lunch's Free Lunch Program (NSL),
Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

ԿԱՄ

ԱՌԱՎԵԼԱԳՈՒՅՆ ԸՆՏԱՆԵԿԱՆ ԵԿԱՄՈՒՏՆ՝
(ուժի մեջ է հունիսի 1, 2009թ. մինչև մայիսի 31, 2010թ.)
*ներկա ընտանեկան եկամուտը բոլոր աղբյուրներից՝ մինչև կրճատումները

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: / Դուք չեք կարող կախյալ համարվել Ձեր ամուսնուց բացի որևէ մեկի եկամտահարկի հայտարարագրում: / Դուք պետք է կրկին վավերացնեք Ձեր դիմումի ձևը, երբ որ խնդրվի: / Դուք պետք է հայտնեք The Gas Company-ին 30 օրվա ընթացքում, եթե այլևս պայմանունակ չեք: / Ձեզանից կարող է խնդրվել ստուգել CARE-ի Ձեր պայմանունակությունը:

ԱՅԼ ԾՐԱԳՐԵՐ ԿԱՄ ԾԱՌԱՅՈՒԹՅՈՒՆՆԵՐ, ՈՐՈՆՑ ԴՈՒՔ ԿԱՐՈՂ Է ՈՐԱԿԱՎՈՐՎԱԾ ԼԻՆԵՔ՝

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 1-800-331-7593 հեռախոսի համարով:

Medical Baseline - Մատակարարում է լրացուցիչ գազի թույլտվություն ավելի ցածր գնով որոշակի առողջական վիճակ ունեցող հաճախորդներին: Լրացուցիչ տեղեկությունների համար զանգահարեք 1-800-427-2200 հեռախոսի համարով:

LIHEAP- Low Income Home Energy Assistance Program մատակարարում է հաշիվների վճարման օգնություն, վթարների օգնություն և եղանակի հետ կապված ծառայություններ: Զանգահարեք California Department of Community Services and Development 1-866-675-6623 հեռախոսի համարով:

California Lifeline - Զեղչով հեռախոսային մուտք՝ CARE-ի նման եկամտային ցուցմունքներին որակավորված հաճախորդների համար: Լրացուցիչ տեղեկությունների համար դիմեք ձեր տեղական հեռախոսային ծառայությունների մատակարարողին:

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

CARE 20% Գնային Զեղչի Դիմում

Խնդրվում է ՄՈՒԳ թանաքով լրացնել և տպատառերով հստակ գրել՝ հարկին գործածումը երաշխավորելու համար Շրջանակները ճիշտ նշելու ձևը. ●

Form 6491-C ARM (9/09)

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

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Հաճախորդի Անուն՝ (ինչպես Ձեզ ուղարկվող հաշիվներում)

Տան հասցե՝ (փողոց, քաղաք, ԻՆԴԵՔՍ)

Հաշվեհամար՝

Հեռախոսահամար՝ ( ) -

Էլեկտրոնային հասցե՝

2

Ձեր ընտանիքում մեծահասակների և երեխաների ընդհանուր թիվը՝ ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

<u>Դուք (կամ որևէ մեկը Ձեր ընտանիքում) մասնակցում եք արդյո՞ք հետևյալ ծրագրերից որևէ մեկին:</u>

○ **<u>ԱՅՈ</u>** *(Եթե այո, ապա նշեք մասնակցության ծրագիր(եր)ը և անցեք հարց 3-ին)*▼

- ○ Medi-Cal: մինչև 65 տարեկան
- ○ Medi-Cal: 65 տարեկան կամ ավել
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **<u>ՈՉ</u>** *(Եթե Ոչ, ապա շարունակեք հետևյալ հարցերը)*►

Եթե ներկայումս չեք մասնակցում վերոհիշյալ ծրագրերից ոչ մեկին, ապա ո՞րն է Ձեր տարեկան եկամուտը (մինչև կրճատումները՝ ընտանիքի բոլոր անդամները ներառյալ):▼

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

○ Եթե $58,000-ից ավել է, ապա լրացրեք այստեղ. $, .00 տարեկան

Խնդրվում է նշել Ձեր եկամտի աղբյուրները. ▼

- ○ Social Security
- ○ SSP կամ SSDI
- ○ Կենսաթոշակ
- ○ Տոկոս կամ շահաբաժին՝ խնայողական հաշիվներից, բաժնետոմսերից, արժեթղթերից կամ թոշակի հաշվից
- ○ Աշխատավարձ և/կամ շահույթ սեփական գործից
- ○ Գործազրկության նպաստ
- ○ Ապահովագրության կամ իրավական լուծում
- ○ Հաշմանդամության վճարում կամ Աշխատողի փոխհատուցում
- ○ Ամուսնության կամ երեխայի օգնություն
- ○ Ուսման թոշակ, գրանտ, կամ այլ օգնություն ապրուստի ծախսերի համար
- ○ Վարձի կամ հարկի եկամուտ
- ○ Կանխիկ կամ այլ եկամուտ

3

Համաձայն եք արդյո՞ք հետևյալին: Խնդրում ենք կարդալ և ստորագրել:
Ես հայտնում եմ, որ այս դիմումի մեջ իմ մատակարարած տեղեկությունները ճշմարիտ են և ճշգրիտ: Ես համաձայն եմ մատակարարել CARE պայմանունակության ապացույց, եթե այն խնդրվի: Ես համաձայն եմ տեղեկացնել The Gas Company-ին, եթե այլևս որակավորված չլինեմ զեղչը ստանալու: ես հասկանում եմ, որ եթե ես զեղչը ստանամ առանց որակավորված լինելու, ինձանից կարող է պահանջվել վերադարձնել ստացած զեղչը: Ես հասկանում եմ, որ The Gas Company-ն կարող է իմ տեղեկությունները կիսել այլ կենցաղային սպասարկման հիմնարկների կամ գործակալների հետ, որպեսզի ես մասնակցեմ նրանց օգնության ծրագրերին:

Ստորագրություն՝ X **Ամսաթիվ՝** / /

Form 6491-C FAR (9/09)

تقاضانامه تخفیف مراقبت برای 20%

A Sempra Energy utility

برنامه نرخهای جایگزین انرژی شرکت گاز برای کالیفرنیا (CARE) برای خانواه های واجد شرایط 20% تخفیف در قبض ماهیانه گازقابل میشود. آنهایی که واجد شرایط بوده وصرف 90 روز ازشروع خدمات جدید گاز مورد تایید قرار گیرند 15 دلار تخفیف از هزینه راه اندازی خدمت خواهند گرفت. تخفیف موقعی صورت میگیرد که تقاضانامه تکمیل و امضاء شده شما توسط شرکت گاز(The Gas Company[SM]) تصویب شده باشد.

لطفا این تقاضا نامه را کامل کرده و در پاکت نامه که در اختیارتان گذاشته شده ارسال دارید, یا از طریق تارنمای ذیل تقاضا کنید:
http://www.socalgas.com/assistance/care/

چگونه می توانید واجد شرایط تخفیف مراقبت (CARE DISCOUNT) بشوید؟

برنامه های کمک عمومی:
(قابل تنفیذ از 1 ماه جون 2009 تا 31 ماه می 2010)
* درآمد کنونی خانوار شامل تمام منابع درآمد قبل از کسورات

تعداد افراد در خانوار	کل در آمد سالانه
2-1	$30,500
3	$35,800
4	$43,200
5	$50,600
6	$58,000
برای هر فرد اضافه بیافزایید	$7,400

یا

برنامه های کمک عمومی:

اگر شما و یا شخص دیگری در خانوار شما در یکی از برنامه های زیر شرکت میکند:

مدی کید (Medicaid), مدیکل (Medi-Cal), خانواده های تندرست (Healthy Families) الف و ب (A&B)
نوزادان و کودکان در برنامه تغذیه مکمل،
(Women, Infant & Children (WIC))
کمک موقط به خانواده های نیازمند (TANF)
واجد شرایط برای برنامه هد استارت (Head Start)-فقط مربوط به قبیله ها
اداره امور سرخپوستان کمک کلی
کوپون غذائی (SNAP)
ناهار در مدارس کشور برنامه ناهار رایگان (NSL)
برنامه برای کمک انرژی درخانه های با درآمد کم (LIHEAP)
درآمد مکمل تآمین اجتماعی (SSI)

شرایط برای شرکت کردن

قبض گاز باید به نام شما 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. / اهنگامی که از شما تقاضا گردد باید تقاضانامه خود را مجدداً تایید نمایید. / اگر شما دیگر واجد شرایط نیستد میباید شرکت گاز را (The Gas Compnay) ظرف 30 روز مطلع سازید. / ممکن است از شما خواسته شود تا صلاحیت خود را برای CARE نشان دهید.

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

LIHEAP: برنامه کمک انرژی برای خانواده های کم در آمد خدمات، کمک پرداخت قبض،کمک اضطراری برای پرداخت قبض, متناسب کردن با آب وهوا را فراهم میکند. با سازمان خدمات اجتماعی وپیشرفت کالیفرنیا (California Dept. of Community Services and Development) به شماره 1-866-675-6623 تماس بگیرید.

California Lifeline:خدمات دسترسی تلفنی با تخفیف برای مشتریانی که شرایط درآمدی مشابهی به CARE دارند. برای اطلاعات بیشتر با فراهم کننده خدمات محلی تلفن خود تماس بگیرید.

DAP: برنامه کمک مستقیم، یک برنامه برای افراد کم در آمد جهت 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 جزیی منزل میشوند. برای اطلاعات بیشتر با این شماره تماس بگیرید: 1-800-331-7593

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:1-800-427-2200

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

تقاضا نامه نرخ تخفیف مراقبت(CARE) 20%

(لطفا از جوهر تیره استفاده کرده و واضح چاپ کنید تا از رسیدگی مناسب اطمینان حاصل شود) روش صحیح برای علامت گذاشتن: ●

Form 6491-C FAR (9/09)

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

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نام و نام خانوادگی مشتری :
(به شکلی که روی صورت حساب نوشته شده است):

نشانی منزل
(خیابان، شهر، کد پستی):

شماره حساب:

شماره تلفن: ( ) -

نشانی پست الکترونیک یا ایمیل:

2

جمع کل افراد بزرگسال و کودکان در خانوار شما: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

آیا شما (یا یکی از اعضای خانواده تان) برای یکی از برنامه های کمکی زیر ثبت نام کرده اید؟

▼آری (اگر پاسختان آری است، برنامه (ها)ی شرکت کننده را علامت بگذارید و به سئوال 3 رجوع کنید) ○

- ○ برنامه کمک برای انرژی خانواده هائی که کم درآمد هستند (LIHEAP)
- ○ درآمد سوشل سکیوریتی مکمل (SSI)
- ○ ناهار **رایگان** در سرتاسر کشور (NSL)
- ○ کمک کلی برای اداره امور سرخپوستان (BIA GA)
- ○ واجد شرایط برای برنامه هد استارت (Head Start) – فقط برای قبیله ها
- ○ مدی کل/مدی کید: زیر سن 65
- ○ مدی کل/مدی کید: 65 یا بالاتر
- ○ گروههای A وB در برنامه خانواده های تندرست
- ○ برنامه زنان، اطفال، و کودکان (WIC)
- ○ کمک موقتی برای خانواده های نیازمند (TANF) یا قبیله ای TANF
- ○ کوپن غذائی/ SNAP

◄ **خیر** *(اگر خیر, لطفاً به سئوال بعدی مراجعه کنید)* ○

اگر شما درحال حاضردر هیچ یک از برنامه های ثبت نام نکرده اید، در آمد سالیانه خانوار شما چقدر میباشد (پیش از کسورات، شامل تمام اعضاء خانوار میشود)؟ ▼

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

اگر سالیانه بیشتر 58.000$ میباشد مقدار را در اینجا بنویسید: $ .00

لطفاً در آمد خود را طبق منابع زیر علامت بگذارید: ▼

- ○ -حمایت از همسر و حضانت کودک
- ○ -بورس تحصیلی، گرانت، یا هر گونه کمک برای هزینه سکونت
- ○ در آمد از کرایه دادن یا حق الامتیاز
- ○ پول نقد یا هر نوع در آمد دیگر
- ○ -دستمزد و/یا حقوق
- ○ -مزایای بیکاری
- ○ -بیمه یا مصالحه های حقوقی
- ○ -از کار افتادگی یا پرداختی های غرامت صدمه دیدن در محل کار
- ○ سوشال سکوریتی
- ○ SSP or SSDI
- ○ حقوق بازنشستگی
- ○ سود یا در آمد از سهام توسط: حسابهای پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی

3

آیا با محتوی متن زیر موافقت میکنید؟ لطفاً بخوانید و در زیر امضاء کنید. من اعلام میکنم که اطلاعاتی را که در این تقاضانامه ارائه داده ام صحیح و درست است. من موافقت میکنم تا در صورت لزوم مدارک اثبات واجد شرایط بودن CARE را فراهم کنم. من موافقت میکنم تا در صورت صلب شرایط شرکت گاز را (The Gas Company) مطلع کنم. من متوجه هستم که در صورت دریافت خدمات بدون داشتن شرایط لازم ممکن است وادار به پس دادن تخفیفی که دریافت کرده ام باشم. من متوجه هستم که شرکت گاز(The Gas Company) میتواند اطلاعات من را در اختیارنمایندگان سایر خدمات شهری (گاز، برق، آب، تلفن و غیرو) بگذارد تا آنها مرا در برنامه های کمک دهنده خود ثبت نام کنند.

امضاء: X

تاریخ: / /

CARE DAIM NTAWV THOV KEV PAB LUV NQI 20%

Lub chaw The Gas Company txoj kev pab cuam hu ua California Alternate Rates for Energy (CARE) muaj kev pab luv 20% rau daim nqi hluav taws xob txhua lub hlis rau cov tsev neeg uas muaj feem lav tau. Cov tsev neeg muaj feem lav tau thiab cov uas tau txais qhov kev pab no nyob rau 90 hnub ntawm kev pib siv hluav taws xob tshiab ho yuav tau $15 luv nqi ntxiv rau qhov hu ua Service Establishment Charge. Qhov luv nqi no yuav pib rau thaum koj sau thiab xee npe tas rau daim ntawv cuv npe thiab lub chaw The Gas Company[SM] tau pom zoo lawm tso.

Thov sau kom txhij rau daim ntawv cuv npe thiab rov muab xa tuaj rau lub hnab ntawv uas muaj nyob nrog daim ntawv lossis mus cuv npe hauv lub hlwb hlau nyob rau ntawm http://www.socalgas.com/assistance/care/

LICAS THIAJ MUAJ FEEM TAU CARE QHOV KEV PAB LUV NQI:

COV KEV PAB CUAM UAS SIV:

Yog koj lossis ib tug hauv tsev neeg nyob rau ib qhov kev pab cuam no:

Medicaid, Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC) (Tshev Mis), TANF, Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, Food Stamps (SNAP) (Nyiaj Muas Noj), National School Lunch's Free Lunch Program (NSL) (Tau Noj Mov Dawb Hauv Tsev Kawm Ntawv), Low Income Home Energy Assistance Program (LIHEAP) (Kev Pab Nqi Hluav Taws Xob), Supplemental Security Income (SSI) (Nyiaj Laus lossis Nyiaj Xiam Oob Khab)

LOSSIS

TUS NYIAJ TSIS PUB TSEV NEEG TAU DHAU*:
(pib rau June 1, 2009 txog May 31, 2010)
*hais txog cov nyiaj tau los rau hauv tsev ua ntej tsis tau txiav se thiab lwm yam

Petsawg Leej Nyob Hauv Tsev Neeg	Tagnrho Cov Nyiaj Tau Los Txwm Ib Xyoos
1-2	$30,500
3	$35,800
4	$43,200
5	$50,600
6	$58,000
Txhua Tus Neeg Tauj Ntxiv Ces, Ntxiv	$7,400

COV CAI NTAWM KEV KOOM QHOV KEV PAB

Daim nqi hluav taws xob yuav tsum yog koj npe thiab qhov chaw nyob yuav tsum yog koj qhov chaw koj nyob kiag. / Koj yuav tsum tsis yog ib tug uas lwm tus siv tau koj npe hauv qab lawv li, tsuas tau rau koj tus txij nkawm xwb. / Koj yuav tsum rov qab muab ntaub ntawv pov thawj dua rau koj daim ntawv cuv npe thaum uas luag yuav kom koj muab. / Koj yuav tsum tiv tauj The Gas Company tsis pub dhau 30 hnub yog tias koj tsis muaj feem cuam txais cov kev pab no lawm. / Koj muaj feem yuav raug nug kom muab ntaub ntawv pov thawj seb koj puas muaj feem yuav tau cov kev pab los ntawm CARE tiag.

LWM HOM KEV PAB CUAM UAS TEJ ZAUM KOJ YUAV MUAJ FEEM TAU TXAIS:

DAP - Direct Assistance Program, ib qho kev pab cuam rau tej tsev uas khwv tau nyiaj txiag 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 1-800-331-7593.

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 1-800-427-2200.

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 – 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

CARE DAIM NTAWV THOV KEV PAB LUV NQI 20%

Thov siv ib tug xaum npiv muaj kua dub tsaus thiab txhob sau ntawv sib cab kom txhob muaj teebmeem thaum muab saib txog.

Txoj Kev Khij Lub Voj Kom Yog●

Form 6491-C HMO (9/09)

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

A Sempra Energy utility

1

Lub Npe (raws li sau rau koj daim nqi):

Chaw Nyob (txoj kev, lub nroog, tus ZIP):

Tus Lej Askhauj:

Tus Xovtooj: ( ) -

Tus E-mail:

2

Tag nrho hauv koj tsev neeg muaj pestsawg leej: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

Koj (lossis puas muaj ib tus hauv koj tsev neeg) uas nyob rau ib qho kev pab cuam li no?

○ **MUAJ** *(Yog muaj no, khij seb nyob rau hom twg, thiab mus rau lej 3)*▼

- ○ Medi-Cal / Medicaid: Hnub Nyug Qis Tshaj 65
- ○ Medi-Cal / Medicaid: 65 lossis Laus Dua
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC) (Tsev Mis)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP (Nyiaj Muas Noj)
- ○ Low Income Home Energy Assistance Program (LIHEAP) (Kev Pab Cuam Luv Nqi Hluav Taws Xob)
- ○ Supplemental Security Income (SSI) (Nyiaj Laus, Nyiaj Xiam Oob Khab)
- ○ National School Lunch's FREE Lunch Program (NSL) (Tau Zaub Mov Noj Dawb Hauv Tsev Kawm Ntawv)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **TSIS MUAJ** *(Yog Tsis Muaj, thov teb cov lus nug no)*►

Yog tias koj tsis nyob rau ib qho kev pab cuam raws li cov saum nov li, khij seb koj cov nyiaj uas tau los hauv tsev neeg (ua ntej txiav se thiab lwm yam, ntawm tagnrho Sawvdaws uake) yog tau licas?

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

○ Yog tias tau ntau tshaj $58,000, sau rau ntawm no: $, .00 tauj ib xyoos

Thov khij seb koj cov nyiaj los qhov twg los: ▼

- ○ Social Security (nyiaj xaus saus)
- ○ SSP or SSDI
- ○ Pensions (nyiaj so haujlwm)
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts (nyiaj peev lagluam khaws nyiaj)
- ○ Wages and/or Profit from Self Employment (nyiaj khiav haujlwm rau tus kheej)
- ○ Unemployment Benefits (nyiaj poob haujlwm)
- ○ Insurance or Legal Settlements (nyiaj hais plaub yeej)
- ○ Disability or Workers Compensation Payments (nyiaj raug mob tom haujlwm)
- ○ Spousal or Child Support (nyiaj yug qub txij nkawm)
- ○ Scholarships, grants, or other aid used for living expenses (nyiaj pab kawm ntawv)
- ○ Rental or Royalty Income (nyiaj ua tswv tsev xauj tsev)
- ○ Cash or Other Income (nyiaj ntsuab lossis lwm yam nyiaj khwv tau los)

3

Koj puas pom zoo raws li cov lus no? Thov nyeem thiab xee hauv qab no.

Kuv cog lus tias cov ntaub ntawv kuv tau sau nyob rau daim ntawv cuv npe no muaj tseeb thiab yeej yog tiag. Kuv pom zoo yuav npaj cov ntaub ntawv pov thawj rau CARE yog tias luag ho nug. Kuv pom zoo qhia rau The Gas Company yog thaum kuv tsis muaj feem cuam txais cov kev pab no lawm. Kuv totaub tias yog kuv tau txais cov kev pab no tiamsis ho tsis yog ib tug yuav tsum muaj feem cuam txais, kuv yuav tau them txwm cov. Kuv totaub tias The Gas Company muaj cai muab kuv cov ntaub ntawv mus rau lwm lub chaw hluav taws xob saib kom lawv muab kuv tso rau lawv cov kev pab thiab los tau.

Xee Npe: X **Hnub Tim:** / /

Form 6491-C KH (9/09)

ក្រដាសដាក់សុំការចុះតម្លៃ ២០ ភាគរយ នៃកម្មវិធីយែរ (CARE)

កម្មវិធីនៃតម្លៃថាមពលនានារដ្ឋកាលីហ្វ័រញ៉ា (California Alternate Rates for Energy - CARE) របស់ក្រុមហ៊ុន The Gas Company ផ្តល់ជាការចុះតម្លៃ 20 ភាគរយនៃការចុះតម្លៃចំពោះសំបុត្រ ទារលុយសំរាប់ផ្ទះសំបែងណាដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលកម្មវិធីនោះ ។ លោកអ្នកដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួល ហើយត្រូវបានអនុញ្ញាតក្នុងកំឡុង 90 ថ្ងៃនៃការចាប់ផ្តើមសេវាកម្មហ្គាសថ្មី ក៏នឹងទទួលការចុះតម្លៃ $15 នៃតម្លៃតម្លើងស្ថាបនា សេវាកម្ម (Service Establishment Charge) ។ ការចុះតម្លៃ នឹងអនុវត្ត ពេលលោកអ្នកបំពេញ និង ចុះហត្ថលេខាក្រដាសសុំនេះ ត្រូវបានសំរេចដោយ ក្រុមហ៊ុន The Gas Company[SM]។

សូមបំពេញក្រដាសសុំ ហើយផ្ញើវាមកវិញនៅក្នុងស្រោមសំបុត្រ ដែលបានផ្តល់ជូនឥល រឺសុំតាមអ៊ិនធឺរណិតតាម http://www.socalgas.com/assistance/care/

មធ្យោបាយដើម្បីនឹងមានលក្ខណៈគ្រប់គ្រាន់ទទួលសំរាប់ការចុះតម្លៃ :

កម្មវិធីជំនួយសាធារណៈ:

បើលោកអ្នក ឬនរណាម្នាក់ទៀតនៅក្នុងផ្ទះរបស់លោកអ្នក ចូលរួមកម្មវិធីណាមួយដូចតទៅ :

- មេឌីខេត មេឌីខាល សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
- ស្ត្រី ទារក ហើយនិង កុមារ (WIC)
- ធែនហ្វ (TANF) ទ្រីបលធែនហ្វ (Tribal TANF)
- សិទ្ធិបានចំណូលជំបួង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតូច
- ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance)
- ប្រាក់រូបិតស្ទែមស៍ (SNAP)
- កម្មវិធីអាហារថ្ងៃត្រង់ឥតគិតថ្លៃរបស់កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch's Free Lunch Program - NSL)
- កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
- ចំណូលសេដ្ឋរទីបន្ថែម (Supplemental Security Income - SSI)

ឬ

ចំណូលគ្រួសាររមតិបរមា *:

(មានប្រសិទ្ធិភាពនៅក្នុងថ្ងៃទី 1 មិថុនា 2009 រហូតថ្ងៃទី 31 ឧសភា 2010)

*ចំណូលគ្រួសារបច្ចុប្បន្នមកពីប្រភពទាំងអស់មុនពេលកាត់ទុក

ចំនួននៃមនុស្សរស់នៅក្នុងផ្ទះ	ចំនួនថវិការៀងរាល់ឆ្នាំ
1-2	$30,500
3	$35,800
4	$43,200
5	$50,600
6	$58,000
សំរាប់ចំនួនសមាជិកនៃផ្ទះបន្ថែមម្នាក់បញ្ចូល	$7,400

លក្ខខណ្ឌចំពោះការចូលរួម

សំបុត្រទារលុយហ្គាសត្រូវតែមានឈ្មោះ និងអាសយដ្ឋានរបស់លោកអ្នក ហើយត្រូវតែមានអាយដ្ឋានចំបងរបស់លោកអ្នក ។ / លោកអ្នកមិនត្រូវធ្វើដាក់ឈ្មោះកូនជាកូនបិតនៅក្នុងបន្ទុកសំអាងទៅលើថវិកានៃនរណាម្នាក់ទៀត ជាជាងប្រពន្ធឬប្តីរបស់លោកអ្នកឡើយ ។ / លោកអ្នកត្រូវតែដាក់ស្នើសុំការបញ្ចាក់ម្តងទៀតចំពោះក្រដាសសុំរបស់លោកអ្នក នៅពេលស្នើសុំ ។ / លោកអ្នកត្រូវតែប្រាប់ក្រុមហ៊ុន The Gas Company អោយដឹងយ៉ាងហោចណាស់ 30 ថ្ងៃ បើលោកអ្នកពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលទៀត ។ / លោកអ្នកប្រហែលជាត្រូវបានស្នើសុំអោយបញ្ជាក់នូវលក្ខណៈគ្រប់គ្រាន់ទទួល CARE របស់លោកអ្នក។

កម្មវិធី និងសេវាកម្មឯទៀត ដែលលោកអ្នកមានលក្ខណៈគ្រប់គ្រាន់ទទួលនឹងទទួល :

ដាប (DAP) – កម្មវិធីនៃជំនួយផ្ទាល់ (Direct Assistance Program) ជាកម្មវិធីសំរាប់ការប្រើប្រាស់ហ៊ាមពលដែលមានប្រសិទ្ធិភាព ទាប ផ្តល់ជាជំនួយចំពោះការសន្សំសំចៃហ៊ាមពលនៅក្នុងផ្ទះ ដោយមិនអស់លុយដូចជា ការជាក់ទ្រនាប់នៅលើពិតាន បន្ទះបិទបង្ហាំងធាតុអាកាស តាមចន្លោះទ្វា ការបិទថ្នាំការបិទ និងការជួសជុលតិចតួចនៃផ្ទះសំបែង ។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-800-331-7593 ។

ម៉ាឌីខាល បេសឡាញ (Medical Baseline) – ផ្តល់ជាប្រាក់ជំនួយខាងហ្គាសដោយមានតម្លៃថោកចំពោះអ្នកទិញ ដែលមានលក្ខខណ្ឌសុខភាពជាក់លាក់។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-800-427-2200។

លីហ្សេប (LIHEAP) – កម្មវិធីជំនួយខាងហ៊ាមពលនៃផ្ទះសំបែងដែលមានថវិកាតិច ផ្តល់ជាជំនួយខាងសំបុត្រទារលុយ ជំនួយខាងសំបុត្រទារលុយបន្ទាន់ ហើយនិងសេវាកម្មខាងរំអោះធាតុអាកាស ។ ទូរស័ព្ទក្រសួងសេវាកម្មសហគមន៍រដ្ឋកាលីហ្វ្រញ៉ា (California Dept. of Community Services) លេខ 1-866-675-6623 ។

ខ្សែនៃជីវិតរដ្ឋកាលីហ្វ្រញ៉ា California Lifeline – លទ្ធភាពចំពោះទូរស័ព្ទដោយមានតម្លៃថោក សំរាប់អ្នកទិញដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួល បំពេញតាមការណែនាំពីចំណូលរបស់ CARE។ សំរាប់ព័ត៌មានបន្ថែម សូមទាក់ទងអ្នកផ្តល់សេវាកម្មខាងទូរស័ព្ទប្រចាំស្រុករបស់លោកអ្នក ។

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

ក្រដាសដាក់ពាក្យសុំចុះឥវ៉ែ 20% នៃកម្មវិធី CARE

Form 6491-C KH (9/09)

សូមប្រើទឹកចិចខ្មៅ ហើយសរសេរដោយច្បាស់ផ្តិតផ្តង់ដើម្បីបញ្ជាក់ដំណើរការយ៉ាងត្រឹមត្រូវ
វិធីត្រឹមត្រូវគូសរង្វង់មួល: ●

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

1

ឈ្មោះរបស់អ្នកទិញ (ដូចមានលើសំបុត្រទារលុយ):

អាសយដ្ឋាន (វដ្ត ក្រុង កូដតំបន់):

លេខកុង:

លេខទូរស័ព្ទ: ( ) -

អាសយដ្ឋានអ៊ីមែល:

2

ចំនួនជនពេញវ័យ និងក្មេងក្នុងគ្រួសាររបស់លោកអ្នកសរុប: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

តើលោកអ្នក (រឺនរណាមួយក្នុងគ្រួសាររបស់លោកអ្នក) ចូលរួមក្នុងកម្មវិធីជំនួយណាមួយខាងក្រោមរឺទេ?

○ **មាន** *(បើមាន សូមគូសកម្មវិធីចូលរួម និងតទៅសំណួរទី 3)*▼

- ○ មេឌីខេត/មេឌីខាល: ក្រោម 65 ឆ្នាំ
- ○ មេឌីខេត/មេឌីខាល: លើ 65 ឆ្នាំ រឺលើសនេះ
- ○ សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
- ○ កម្មវិធីស្ត្រី ទារក ហើយនិង កុមារ (WIC)
- ○ ជំនួយបណ្តោះអាសន្នសម្រាប់គ្រួសារដែលត្រូវការ (TANF) រឺទ្រីបលធែនហ្វ (Tribal TANF)
- ○ ប្រាក់ភូតស្នៃមស៍/SNAP
- ○ កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
- ○ ចំណូលសេគ្យូរីទីបន្ថែម (Supplemental Security Income - SSI)
- ○ កម្មវិធីអាហារថ្ងៃត្រង់តតិតថ្លៃរបស់កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch's Free Lunch Program - NSL)
- ○ ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance - BIA GA)
- ○ សិទ្ធិបានចំណូលពីបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច

○ **មិនមាន** *(បើមិនមាន សូមតទៅសំណួរខាងក្រោម)*►

បើលោកអ្នកមិនចូលរួមនៅក្នុងកម្មវិធីណាមួយដែលបានបរិយាយនៅខាងលើទេ តើចំណូលគ្រួសារប្រចាំឆ្នាំរបស់លោកអ្នក (មុនពេលកាត់ រួមសមាជិកគ្រួសារទាំងអស់) មានប៉ុន្មាន? ▼

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

○ បើច្រើនជាង $58,000 ដាក់បញ្ចូលចំនួនកន្លែងនេះ: $,.00 ក្នុងមួយឆ្នាំ

គូសយកប្រភពចំណូលរបស់លោកអ្នក: ▼

- ○ សូស្យាល់សេគ្យូរីទី
- ○ SSP រឺ SSDI
- ○ លុយរីតៃ្រត
- ○ ការប្រាក់ ឬក៏រំក្រុមហ៊ុនពី: កុងសន្យ៉ា ប្រាក់ Stocks, Bonds រឺលុយរីតៃ្រត
- ○ ប្រាក់ខែ និង/ឬប្រាក់ចំណេញពីពាណិជ្ជកម្មផ្ទាល់ខ្លួន
- ○ ប្រាក់អត្ថប្រយោជន៍ពីការឥតការធ្វើ
- ○ ប្រាក់មកពីអ៊ិនសួរិន រឺប្រាក់មកពីការកាត់សេចក្តី
- ○ ប្រាក់ពិការ រឺសំណងកម្មករ
- ○ ប្រាក់ជំនួយពីប្តីឬប្រពន្ធ រឺជំនួយកូន
- ○ ប្រាក់ជំនួយអាហារូបករណ៍ ជំនួយ រឺជំនួយអ៊ីទៀតប្រើសំរាប់ការចាយវាយនៃពីវាភាព
- ○ ប្រាក់មកពីការជួល រឺសួយសារ
- ○ ប្រាក់សុទ្ធ /ឬចរិកាអ៊ទៀត

3

តើលោកអ្នកព្រមចំពោះការរៀបរាប់ខាងក្រោមទេ? សូមអាន ហើយចុះហត្ថលេខាខាងក្រោម ។

ខ្ញុំសូមថ្លែងថាពិតមានដែលខ្ញុំបានផ្តល់នៅក្នុងក្រដាសដាក់សុំនេះ គឺពិតហើយត្រូវ ។ ខ្ញុំយល់ព្រមនឹងផ្តល់នូវភស្តុតាងសំរាប់លក្ខណៈគ្រប់គ្រាន់ទទួលនៃ CARE ប្រសិនជាត្រូវបានស្នើសុំ ។ ខ្ញុំយល់ព្រមនឹងប្រាប់ក្រុមហ៊ុន The Gas Company ប្រសិនបើខ្ញុំពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលដើម្បីនឹងទទួលការចុះថោកទេ ។ ខ្ញុំយល់ថា បើខ្ញុំទទួលការចុះថោកដោយមិនឆ្លងលក្ខណៈគ្រប់គ្រាន់ទទួល ខ្ញុំអាចត្រូវបានតំរូវឲ្យបង់សងការចុះថោកដែលខ្ញុំបានទទួល ។ ខ្ញុំយល់ថា ក្រុមហ៊ុន The Gas Company អាចចែកចាយពត៌មានរបស់ខ្ញុំជាមួយនឹងក្រុមហ៊ុន និងភ្នាក់ងារអ៊ទៀតដើម្បីចុះឈ្មោះខ្ញុំនៅក្នុងកម្មវិធីជំនួយរបស់គេ។

ហត្ថលេខា: X **ថ្ងៃខែ:** / /

ЗАЯВЛЕНИЕ НА 20% СКИДКУ ПО ПРОГРАММЕ CARE

A Sempra Energy utility

Компания The Gas Company предлагает сниженный тариф за пользование энергоресурсами в штате Калифорния (программа CARE). 20% скидка предоставляется правомочным одиноким лицам и семьям и отражается в их ежемесячном счете за пользование услугами. Клиенты, подписавшие и подавшие заявление, получают скидку после утверждения данной заявки компанией The Gas Company[SM] , а также в течение 90 дней после открытия нового счета они имеют право на $15-ую скидку на оплату установки услуг (Service Establishment Charge).

Пожалуйста, заполните бланк и отошлите его в предоставленном конверте или подайте заявление онлайн с вебсайта http://www.socalgas.com/assistance/care/

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

ЕСЛИ ВЫ ПОЛУЧАЕТЕ ПРОГРАММЫ ПОМОЩИ:
Если вы или кто-либо из проживающих с вами членов семьи получает льготы по одной из следующих программ: Medicaid, Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC), TANF, Tribal TANF, Head Start Income Eligible - только для проживающих в индейских резервациях, социальное пособие Бюро по делам индейцев, продовольственные талоны (SNAP), государственная программа бесплатных завтраков в школе (NSL), программа пособий на отопление жилья для малоимущих (LIHEAP), дополнительное пособие по социальному обеспечению (SSI)

ИЛИ

ВАШ ОБЩИЙ СЕМЕЙНЫЙ ДОХОД НЕ ПРЕВЫШАЕТ*:
(утверждено на период с 1 июня 2009 до 31мая 2010)
*совокупный семейный доход из всех источников до любых вычетов

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 приходить 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 теплоизоляцию потолков, герметизацию дверных прокладок, уплотнение внутренних стыков и небольшие ремонтные работы. За дополнительной информацией обращайтесь по телефону 1-800-331-7593.

Medical Baseline: Данная программа позволяет оплату определенного количества использованного газа по сниженным расценкам клиентам с определенными заболеваниями. За дополнительной информацией обращайтесь по телефону 1-800-427-2200.

LIHEAP: Программа пособий на отопление жилья для малоимущих (Low Income Home Energy Assistance Program) предлагает помощь в оплате определенных домашних счетов, оплате счетов в чрезвычайных ситуациях и в оплате строительных услуг с учетом климатических особенностей района. Звоните в калифорнийский Отдел коммунально-бытового обслуживания по телефону 1-866-675-6623.

California Lifeline : Скидки на телефонные тарифы для клиентов, отвечающих требованиям сходным с требованиями 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

Бланк заявки на 20% скидку по программе CARE

Пожалуйста, пишите темными чернилами и печатными буквами, четко закрашивая кружки для правильной обработки заявки: ●

Бланк 6491-C RU (9/09)
THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1

Имя и фамилия клиента (как на счете):

Домашний адрес (номер дома, улица, номер квартиры, город, штат, почтовый индекс):

Номер счета:

Номер телефона: ( ) -

Адрес электронной почты:

2

Число членов вашей семьи (включите себя, всех взрослых и детей): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

Получаете ли вы (или кто-либо из проживающих с вами членов семьи) льготы по любой из следующих программ?

○ **ДА** *(Если да, то укажите соответствующие программы и перейдите непосредственно к вопросу 3)*▼

- ○ Medi-Cal / Medicaid: до 65 лет
- ○ Medi-Cal / Medicaid: 65 лет и старше
- ○ Healthy Families, категории A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Временная помощь нуждающимся семьям (TANF) либо Tribal TANF
- ○ Продовольственные талоны / SNAP
- ○ Программа пособий для малоимущих на отопление жилья (LIHEAP)
- ○ Дополнительное пособие по социальному обеспечению (SSI)
- ○ Государственная программа бесплатных завтраков в школе (NSL)
- ○ Социальное пособие Бюро по делам индейцев (BIA GA)
- ○ Head Start Income Eligible - только для проживающих в индейских резервациях

○ **НЕТ** *(Если нет, то ответьте на следующие вопросы)*►

Если вы в настоящее время не получаете льгот ни по одной из вышеуказанных программ, закрасьте, пожалуйста, кружок, который соответствует размеру вашего совокупного семейного дохода (до всех вычетов; включая доходы всех членов семьи, проживающих с вами).▼

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

○ Если ваш доход превышает 58 000$, то укажите здесь его размер: $ .00 в год

Укажите, пожалуйста, источники вашего дохода: ▼

- ○ Social Security (социальное обеспечение)
- ○ SSP или SSDI
- ○ Пенсии
- ○ Прибыль и дивиденды от: сберегательных счетов, акций, облигаций и пенсионных счетов
- ○ Зарплата и (или) доходы от инд. предпр. деят-ти
- ○ Пособие по безработице
- ○ Страховые выплаты и выплаты по искам
- ○ Пособие по инвалидности и компенсации за травмы на работе
- ○ Пособие на супруга и алименты на детей
- ○ Стипендии, гранты и иные компенсации на проживание
- ○ Доходы от аренды и гонорары
- ○ Выплаты наличными или иной доп. доход

3

Согласны ли вы со следующим? Пожалуйста, прочтите и распишитесь.

Я удостоверяю, что информация, которую я предоставил/а в данном заявлении, достоверна и правильна. Я обязуюсь по требованию предъявить доказательства моей правомочности на программу CARE. Я обязуюсь уведомить компанию The Gas Company, если я потеряю свои права на данную скидку. Я принимаю к сведению, что, если я получаю скидку, не имея на это право, от меня могут потребовать выплату всех полученных компенсаций. Я разрешаю компании The Gas Company передавать мою личную информацию другим поставщикам коммунальных услуг или их агентам для последующей регистрации меня в других программах пособий.

Подпись: X **Дата:** / /

Form 6491-C TAG (9/09)

APPLICATION PARA SA 20% NA DISKUWENTO SA CARE

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. Ang mga naging kwalipikado at naaprubahan sa loob ng 90 araw mula sa pag-uumpisa ng bagong serbisyong gas ay makakatanggap din ng $15 na diskuwento sa Service Establishment Charge. Ibibigay ang diskuwento kapag naaprubahan ng The Gas Company℠ ang inyong kumpleto at nilagdaang application form.

Mangyaring kumpletuhin ang application form at ibalik sa nakapaloob na sobre o mag-apply online sa http://www.socalgas.com/assistance/care/

PAANO MAGING KWALIPIKADO PARA SA DISKUWENTONG CARE:

MGA PROGRAMANG NAGBIBIGAY NG TULONG SA MADLA:
Kung kayo o isa sa inyong mga kasambahay ay nakikilahok sa alinman sa mga sumusunod na programa:
Medicaid, Medi-Cal, Healthy Familes A&B
Women, Infants & Children (WIC)
TANF, Tribal TANF
Head Start Income Eligible – Tribal Lamang
Bureau of Indian Affairs General Assistance
Food Stamps (SNAP)
Free Lunch Program ng National School Lunch (NSL)
Low Income Home Energy Assistance Program (LIHEAP)
Supplemental Security Income (SSI)

O

MGA HANGGANAN NG KITA NG SAMBAHAYAN*:
(may-bisa Hunyo 1, 2009 hanggang Mayo 31, 2010)
*kasalukuyang kita ng sambahayan mula sa lahat ng pinagkukunan bago mga kabawasan

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 sambahayan, magdagdag ng	$7,400

MGA KONDISYON NG 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 karapat-dapat sa CARE.

MGA IBANG PROGRAMA AT SERBISYO NA MAAARI KAYONG MAGING KWALIPIKADO:

DAP – Ang 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 mga pintuan, caulking at maliliit na pagpapakumpuni ng bahay. Para sa karagdagang impormasyon, mangyaring makipag-alam sa 1-800-331-7593.

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, makipag-alam sa 1-800-427-2200.

LIHEAP – Ang Low Income Home Energy Assistance Program ay nagbibigay ng tulong sa pagbayad ng 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 - 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 lokal na tagatustos ng 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)
Tumpak na pagmarka ng mga bilog: ●

Form 6491-C TAG (9/09)
THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

A Sempra Energy utility

1

Pangalan ng Mamimili (gaya ng nakalista sa kuwenta):

Tirahan (kalye, lungsod, ZIP):

Numero ng Kuwenta:

Telepono: ( ) -

E-mail Address:

2

Kabuuang bilang ng mga may sapat na gulang at mga bata sa inyong sambahayan: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

Kayo ba (o isa sa inyong mga kasambahay) ay nakikilahok sa alinman sa mga sumusunod na programang nagbibigay ng tulong?

○ **Oo** *(Kung oo, markahan ang (mga) programa kung saan kayo nakikilahok, at pumunta sa tanong 3)*▼

- ○ Medi-Cal / Medicaid: Mas mababa kaysa Edad 65
- ○ Medi-Cal / Medicaid: 65 o higit
- ○ Healthy Families mga kategoriya A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) o Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ FREE Lunch Program ng National School Lunch (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Lamang

○ **HINDI** *(Kung Hindi, mangyaring magpatuloy sa mga sumusunod na tanong)*►
Kung hindi kayo lumalahok sa anuman sa mga programa sa itaas, ano ang taunang kita ng inyong pamamahay (bago mga pagbabawas, kasama ang kita ng lahat ng inyong mga kasambahay)?▼

○ $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

Pakisuyong markahan ang mga pinagkukunan ng kita: ▼

- ○ Social Security
- ○ SSP o SSDI
- ○ Mga Pensiyon
- ○ Mga Interes o Dibidendo galing sa: Savings, Stocks, Bonds, o Retirement Account
- ○ Mga Suweldo at/o Kita galing sa Self Employment
- ○ Unemployment Benefits
- ○ Mga Insurance o Legal Settlement
- ○ Mga kabayaran galing sa Disability o Workers Compensation
- ○ Spousal o Child Support
- ○ Mga scholarship, grant, o ibang tulong na ginagamit sa mga gastos pambuhay
- ○ Rental o Royalty Income
- ○ Kuwarta o Ibang Kita

3

Sumasang-ayon ba kayo sa sumusunod? Mangyaring basahin at lumagda sa ibaba.
Isinasaad ko na ang impormasyong aking ibinigay sa aplikaysong ito ay tapat at tumpak. Sumasang-ayon ako na kung ako ay hihilingan, papatunayan ko na ako'y karapat-dapat 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 at ako'y hindi 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 utilities o mga ahente upang matala ako sa kanilang mga programang nagbibigay ng tulong.

Lagda: X **Petsa**: / /

A Sempra Energy utility

20% CARE DISCOUNT
ใบสมัครเข้าร่วมโครงการ

โครงการ California Alternate Rates for Energy (CARE) โดย The Gas Company มอบส่วนลด 20% ของค่าบริการการใช้ก๊าซรายเดือนให้กับครัวเรือนที่มีสิทธิ์เข้าร่วมโครงการ ผู้ที่ผ่านข้อกำหนดและได้รับการตอบรับเข้าร่วมโครงการภายใน 90 วันหลังจากการเริ่มต้นรับบริการใช้ก๊าซธรรมชาติจะได้รับส่วนลดอีก $15 สำหรับค่าธรรมเนียมเริ่มต้นบริการ (Service Establishment Charge) ทั้งนี้ท่านจะได้รับส่วนลดต่อเมื่อท่านกรอกข้อมูลและลงนามในใบสมัครอย่างครบถ้วน และหลังจากใบสมัครของท่านได้รับการอนุมัติจาก The Gas Company[SM]

กรุณากรอกใบสมัครให้ครบถ้วนและส่งคืนโดยใช้ซองที่ให้มา หรือสมัครออนไลน์ได้ที่
http://www.socalgas.com/assistance/care/

วิธีในการผ่านเกณฑ์สำหรับการรับส่วนลด THE CARE DISCOUNT:

โครงการความช่วยเหลือสาธารณะ: **(PUBLIC ASSISTANCE PROGRAMS:)**
ในกรณีที่ท่านหรือสมาชิกในครอบครัวได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้:
ความช่วยเหลือทางการแพทย์, ค่ารักษาพยาบาล, สุขภาพของครอบครัว A&B, โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC), โครงการช่วยเหลือการเงินชั่วคราวสำหรับครอบครัวที่ขาดแคลน (TANF), กลุ่มTANF, โครงการ Head Start เพื่อช่วยเหลือเด็กและครอบครัวที่มีรายได้น้อยเฉพาะกลุ่ม, สำนักงานให้ความช่วยเหลือทั่วไปสำหรับอเมริกันอินเดียน (Bureau of Indian Affairs General Assistance), โปรแกรมสแตมป์อาหารสำหรับผู้มีรายได้น้อย (SNAP), โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSL), โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP), โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)

หรือ

รายได้รวมสูงสุดของครัวเรือน*: ***(มีผลตั้งแต่ 1 มิถุนายน 2009 ถึง 31 พฤษภาคม 2010)*** *รายได้รวมของครัวเรือนจากทุกแหล่งรายได้ ก่อนการหักค่าใช้จ่าย	
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

ใบเรียกเก็บเงินค่าบริการก๊าซต้องเป็นชื่อของท่านและที่อยู่ต้องเป็นที่อยู่หลักของท่าน / ท่านต้องไม่ใช้สิทธิ์เป็นผู้อยู่ในความดูแล (Dependent) ของผู้อื่น นอกเหนือจากคู่สมรสของท่านในการเสียภาษีรายได้ / ท่านต้องแสดงหลักฐานตามที่ระบุไว้ในใบสมัครอีกครั้งหากมีการร้องขอ / ท่านต้องแจ้งให้ The Gas Company ทราบภายใน 30 วัน หากท่านขาดสถานะภาพในการเข้าร่วมโครงการ / ท่านอาจถูกร้องขอให้แสดงหลักฐานยืนยันว่าท่านมีสิทธิ์ในการเข้าร่วมโครงการ CARE

โครงการและบริการอื่นๆ ที่ท่านอาจผ่านเกณฑ์ในการเข้าร่วม:

DAP: Direct Assistance Program (โครงการให้ความช่วยเหลือโดยตรง), เป็นโครงการสำหรับผู้มีรายได้น้อยเพื่อให้ผู้เข้าร่วมโครงการสามารถใช้พลังงานได้อย่างมีประสิทธิภาพ, โครงการนี้จะมอบอุปกรณ์ประหยัดพลังงาน เช่น ฉนวนฝ้าเพดาน, ฐานใต้ประตูเพื่อกันลมและฝน, บริการการปรับปรุงและซ่อมแซมเล็กๆ น้อยๆ ในบ้าน โดยไม่คิดค่าใช้จ่ายใดๆ ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้ที่หมายเลข 1-800-331-7593.

Medical Baseline: (โครงการบริการทางการแพทย์ขั้นพื้นฐาน) โครงการนี้จะมอบสิทธิเพิ่มเติมในการใช้ก๊าซในอัตราต่ำกว่า ราคาปกติแก่ผู้ใช้บริการที่มีอาการป่วยบางประเภท ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้ที่หมายเลข 1-800-427-2200.

LIHEAP: Low Income Home Energy Assistance Program (โครงการความช่วยเหลือด้านพลังงานในบ้านสำหรับผู้มีรายได้น้อย) โครงการนี้จะมอบความช่วยเหลือในการชำระค่าบริการ ความช่วยเหลือในการชำระค่าบริการในกรณีเกิดเหตุฉุกเฉินและการปรับปรุงอาคารเพื่อเพิ่มประสิทธิภาพในการประหยัดพลังงาน ท่านสามารถติดต่อสอบถามข้อมูลได้ที่สำนักงานบริการและการพัฒนาสาธารณะแห่งรัฐแคลิฟอร์เนีย (California Department of Community Services and Development) ที่หมายเลขโทรศัพท์ 1-866-675-6623.

California Lifeline : (โครงการส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยของรัฐแคลิฟอร์เนีย) โครงการนี้จะมอบส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้อยู่ในเกณฑ์เดียวกับผู้มีสิทธิเข้าร่วมโครงการ CARE ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้จากผู้ให้บริการโทรศัพท์ในท้องที่ของท่าน

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

ใบสมัคร CARE 20% Rate Discount

Form 6491-C TH (9/09)

กรุณาในกรอกข้อมูลให้ครบถ้วนด้วยตัวบรรจง โดยใช้หมึกสีเข้ม
ฝนทำเครื่องหมายวงกลม: ●

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

1

ชื่อลูกค้า (ตามใบแจ้งหนี้):

ที่อยู่ (ถนน, เมือง, รหัสไปรษณีย์):

หมายเลขบัญชี:

หมายเลขโทรศัพท์: ( ) -

อีเมล์:

2

จำนวนสมาชิกทั้งหมดในครัวเรือนของท่าน: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

ท่าน (หรือสมาชิกในครัวเรือนของท่าน) ได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้หรือไม่?

○ **ใช่** *(ถ้าใช่, ให้ทำเครื่องหมายหน้าโปรแกรมที่เข้าร่วม และไปยังคำถามข้อที่ 3)*▼

- ○ Medi-Cal / Medicaid: อายุน้อยกว่า 65 ปี
- ○ Medi-Cal / Medicaid: อายุ 65 ปีขึ้นไป
- ○ โปรแกรมสุขภาพของครอบครัว A & B
- ○ โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC)
- ○ โครงการช่วยเหลือการเงินชั่วคราวสำหรับครอบครัวที่ขาดแคลน (TANF), กลุ่ม TANF
- ○ โปรแกรมสแตมป์อาหารสำหรับผู้มีรายได้น้อย / SNAP
- ○ โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP)
- ○ โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)
- ○ โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSL)
- ○ สำนักงานให้ความช่วยเหลือทั่วไปต่ออเมริกันอินเดียน (BIA GA)
- ○ โครงการ Head Start เพื่อช่วยเหลือเด็กและครอบครัวที่มีรายได้น้อย

○ **ไม่ใช่** *(ถ้าไม่ใช่, ให้ตอบคำถามดังต่อไปนี้)*►

หากท่านไม่ได้ร่วมโครงการใดๆ ที่ระบุไว้ข้างต้น, รายได้ของครัวเรือนต่อปีของท่านเท่าไหร่ (ก่อนหักค่าใช้จ่าย, รวมทั้งสมาชิกในครัวเรือนทุกคน)?▼

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

○ หากรายได้ของท่านมากกว่า $58,000, โปรดระบุจำนวนรายได้ที่นี่: $,.00 ต่อปี

กรุณาระบุแหล่งรายได้: ▼

- ○ เงินประกันสังคม
- ○ SSP หรือ SSDI
- ○ เงินบำนาญ
- ○ ดอกเบี้ยเงินฝาก หรือเงินปันผล: บัญชีออมทรัพย์, หุ้น, พันธบัตร, หรือบัญชีสำหรับผู้เกษียณ
- ○ ค่าจ้าง และ/หรือ กำไรจากอาชีพอิสระ
- ○ สิทธิผลประโยชน์จากการว่างงาน
- ○ เงินประกันหรือเงินที่ได้จากการชำระหนี้ตามกฎหมาย
- ○ เงินชดเชยทุพพลภาพ หรือเงินชดเชยแรงงาน
- ○ เงินช่วยเหลือคู่สมรสหรือบุตร
- ○ ทุน, เงินสนับสนุน, หรือเงินช่วยเหลืออื่นๆ ที่ใช้ในการครองชีพ
- ○ ค่าเช่าหรือรายได้จากค่าลิขสิทธิ์
- ○ เงินสด หรือรายได้อื่นๆ

3

ท่านเห็นด้วยกับข้อความต่อไปนี้หรือไม่? กรุณาอ่านและลงนามด้านล่าง
ข้าพเจ้ารับรองว่าข้อมูลที่ข้าพเจ้าระบุในเอกสารใบสมัครฉบับนี้ถูกต้องและเป็นความจริง หากมีการร้องขอ ข้าพเจ้ายินยอมที่จะแสดงหลักฐานที่แสดงว่าข้าพเจ้ามีสิทธิ์เข้าร่วมโครงการ CARE ข้าพเจ้าตกลงจะแจ้ง The Gas Company ทันทีที่ข้าพเจ้าขาดสถานภาพในการได้รับส่วนลดจากโครงการ ข้าพเจ้าตกลงว่า หากข้าพเจ้าได้รับส่วนลดโดยที่ข้าพเจ้าไม่ผ่านเกณฑ์ในการเข้าร่วมโครงการ ข้าพเจ้าอาจต้องจ่ายคืนส่วนลดที่ข้าพเจ้าได้รับ ข้าพเจ้าตกลงว่า The Gas Company สามารถเปิดเผยข้อมูลของข้าพเจ้ากับเจ้าหน้าที่หรือบริษัทสาธารณูปโภคอื่นๆ เพื่อลงทะเบียนข้าพเจ้าในโครงการช่วยเหลืออื่นๆ ได้

ลายเซ็น: X **วันที่:** / /

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

(See Attached Form)

Form 6674-C EN (09/09)

YOUR RATE DISCOUNT IS EXPIRING

Dear Customer: Date:

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 Recertification 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 someone in your household participates in any of these programs:

Medicaid, Medi-Cal, Healthy Families A&B,
Women, Infants, & Children (WIC),
TANF, Tribal TANF,
Head Start Income Eligible - Tribal Only,
Bureau of Indian Affairs General Assistance,
Food Stamps (SNAP),
National School Lunch's Free Lunch Program (NSL), Low Income Home Energy Assistance Program (LIHEAP),
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2009 to May 31, 2010)
*current household income from all sources before deductions

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.

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:

CARE 20% Rate Discount Recertification Form

Please use DARK ink and print clearly to ensure proper processing

Correct way to mark circles: ●

Form 6674-C EN (09/09)

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

1

Customer Name (as it appears on your bill):

Home Address (street, city, ZIP):

Account Number:

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐

E-mail 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 go directly to #3, **sign** at the bottom, and mail this form in the postage paid envelope provided within 90 days.*

2

Total # of adults and children in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

Are you (or someone in your household) enrolled in any of the following assistance programs?

○ **YES** *(If yes, mark the program(s) of participation, and go to question 3)*▼

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **NO** *(If No, please continue with following questions)*►

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)?▼

○ $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

Please mark your sources of income: ▼

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, grants, or other aid used for living expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Do you agree to the following? 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:** ☐☐ / ☐☐ / ☐☐

Form 6674-C SP (09/09)

EL DESCUENTO EN SU TARIFA ESTÁ POR VENCER

Apreciable cliente: Fecha:

Actualmente recibe en la factura mensual de gas un descuento del 20% en la tarifa a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company. Para continuar recibiendo el descuento CARE, debe renovar su derecho a participar en un plazo 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. Llame al 1-866-716-3452 en cualquier momento las 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,

O

3. Visite nuestro sitio Web www.socalgas.com/care/recert/ y tenga listo su número de cuenta.

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:

Si usted o alguien que vive en su hogar participa en cualquiera de estos programas:

Medicaid/Medi-Cal, Familias Sanas Categorías A & B,
Programa para Mujeres, Infantes, y Niños (WIC),
Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal,
Cupones para alimentos / SNAP,
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP),
Ingreso Suplementario del Seguro Social (SSI),
Programa de Almuerzo "National School Lunch's FREE" (NSL),
Agencia de Asuntos Indios, Asistencia General (BIA GA),
Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

O

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

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 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 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/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

Número de cuenta:

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

Form 6674-C SP (09/09)

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
Forma correcta de marcar los círculos: ●

1

Nombre del cliente (tal como aparece en su factura):

Domicilio:

Número de cuenta:

Teléfono: (☐☐☐)☐☐☐-☐☐☐☐

Dirección de correo electrónico:

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

2

Número total de adultos y niños que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6: ☐

¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **Sí** *(Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3)* ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes, y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

○ **No** *(Si su respuesta es negativa, por favor continúe con las siguientes preguntas)*►

Si no está inscrito actualmente en ninguno de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

○ $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

Por favor marque sus fuentes de ingreso: ▼

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o Indemnización para los trabajadores
- ○ Pensión conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

3

¿Acepta usted lo siguiente? Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar comprobantes de elegibilidad para CARE si se me solicita. 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** : ☐☐ / ☐☐ / ☐☐

Form 6674-C CH (09/09)

您的費率折扣即將過期

親愛的客戶：　　日期：

您現在正通過 The Gas Company 的加州能源優惠 (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。您可以用以下 3 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 (Recertification Form) 上簽名，用所提供的信封寄回。

或者

2. 一周七天、一天 24 小時致電 1-866-716-3452，按照提示在電話上進行重新認證。

或者

3. 訪問網站 www.socalgas.com/care/recert/，請準備好您的賬戶號碼。

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：

Medicaid / Medi-cal（加州醫療輔助計劃）、 Healthy Families A&B（健康家庭低費兒童醫療健保計劃類別 A 及 B）、 Women, Infants & Children （WIC－ 婦女,嬰兒和兒童營養輔助計劃）、 TANF（貧困家庭臨時現金資助計劃）、部落 TANF、 Head Start Income Eligible （學前教育班補助金計劃，僅限於部落）、 Bureau of Indian Affairs General Assistance （印第安事務局一般協助計劃）、Food Stamps （SNAP，食物券）、 National School Lunch's Free Lunch Program（NSL，全國學童免費午餐計劃）、 Low Income Home Energy Assistance Program （LIHEAP，低收入家庭能源協助計劃）、Supplemental Security Income （SSI，社會安全輔助金）

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）

*包括所有來源的家庭現有稅前收入

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。

若需更多關于 CARE 計劃的資訊，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

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

賬戶號碼：

CARE 20% 費率折扣資格重新認證表格

Form 6674-C CH (09/09)

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

請用深色筆以正楷填寫清晰以確保適當受理
正確涂圈方法：●

1

客戶姓名：

地址：

帳戶號碼：

聯絡電話：(□□□)□□□-□□□□

電郵地址：

○ **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(●)，請直接填写第 3 部分，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。*

2

您家庭中的總人數： ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 如果超過 6: □

<u>您（或您的家人）是否有人參加了以下協助計劃？</u>

○ **<u>是</u>** *（請把您或您家人所接受福利的計劃前塗黑， 然後直接到問題 3）*▼

- ○ 加州醫療輔助計劃: 低于 65 歲
- ○ 加州醫療輔助計劃: 65 歲或更大年齡
- ○ 健康家庭低費兒童醫療健保計劃類別 A 及 B
- ○ WIC - 婦女，嬰兒和兒童營養輔助計劃
- ○ TANF（貧困家庭臨時現金資助計劃）或 部落 TANF
- ○ 食物券 / SNAP
- ○ LIHEAP 低收入家庭能源協助計劃
- ○ 社會安全輔助金 (SSI)
- ○ 全國學童免費午餐計劃 (NSL)
- ○ 印第安事務局一般援助
- ○ 學前教育班補助金計劃（僅限於部落）

○ **<u>否</u>** *（如果回答為否，請繼續以下問題）*►

如果您沒有參加以上任何計劃，請按照您的家庭年收入（税前收入，包括所有家庭成員），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

○ 如果多于 $58,000，請在此處填寫金額：$□□,□□□.00 每年

請把您家庭收入所有來源前面的圓圈塗黑：▼

- ○ 社會安全福利金 Social Security
- ○ 社會安全輔助金 SSP, SSDI
- ○ 退休金
- ○ 從以下項目獲取的利息或紅利:儲蓄賬戶、股票、債券，或退休賬戶
- ○ 工資或薪金
- ○ 失業救濟金
- ○ 保險或法律賠償
- ○ 殘疾津貼或勞工補償
- ○ 配偶或子女支付的贍養費
- ○ 獎學金, 助學金, 或其它用于支付生活費用的助學津貼
- ○ 租金或權利金收入
- ○ 現金或其它收入

3

您同意以下聲明嗎？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它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：**□□ / □□ / □□

Form 6674-C (09/09) KO

귀하의 요금 할인이 종료됩니다

친애하는 고객님: 날짜:

귀하께서는 현재 The Gas Company 의 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. 전화번호 1-866-716-3452 에 연중 무휴로 하루 24 시간 아무 때난 전화하여 재증명 지시에 따르십시오. 좌번호를 준비하십시오. 귀하의 구좌번호는 이 페이지 맨 아래에 있습니다.

또는

3. 구좌 번호를 갖추고 저의 웹사이트www.socalgas.com/care/recert/ 를 방문하여 갱신에 임하실 수 있습니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:
귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:
메디케이드(Medicaid) , Medi-Cal, 건강한 가족 유형 A 및 B (Healthy Families A&B), 여성, 유아 및 어린이 (WIC), TANF 또는 부족 TANF, 헤드 스타트 소득 자격 (Head Start - Income Eligible) (인디안 부족만 해당), 인디언 업무 일반 보조국(Bureau of Indian Affairs General Assistance), 푸드 스탬프(Food Stamps, SNAP), 학교 무료 점심 프로그램 (National School Lunch's Free Lunch Program, NSL), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)

또는

최대 가구 소득*: *(2009. 6. 1 부터 2010. 5. 31 까지 유효)* *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1-2	$30,500
3	$35,800
4	$43,200
5	$50,600
6	$58,000
추가되는 식구 1 인당 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 30 일 이내에 The Gas Company 에 통보해야 합니다. / CARE 에 대한 수혜자격을 입증하도록 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 광동어: 1-800-427-1420 월남어: 1-800-427-0478

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

구좌 번호:

CARE 20% 요금 할인 재증명 양식

정확히 처리되도록 하기 위해 진한 펜을 사용하여 분명히 인쇄체로 기입
동그라미에 바르게 표시하는 방법: ●

Form 6674-C KO (09/09)

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

1

고객 이름:

주소:

구좌 번호:

주택 전화번호: (□□□)□□□-□□□□

이메일 주소:

○ **본인은 더 이상 자격이 없거나 CARE 에 참여하기를 원치 않습니다. 본인의 구좌를 CARE 프로그램에서 삭제하십시오.**
←이 동그라미(●) 안을 채운 경우, 직접 3 번으로 가서 하단에 **서명하여** 이 양식을 제공된 우송료 선불 봉투에 넣어 **90** 일 내에 우송하십시오.

2

귀 가구의 총 식구 수: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 만약 6 개 이상: □

귀하 (또는 식구 중 누군가)는 다음 보조 프로그램에 등록되었습니까?

○ **예** *(예인 경우 참여 프로그램에 표시하고 3 번 질문으로 가십시오.)*▼

- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 미만
- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 이상
- ○ 가정 건강 유형 (Healthy Families Categories) A & B
- ○ 여성, 유아 및 어린이 프로그램(WIC)
- ○ 불우 가정 임시 보조(TANF) 또는 인디언 부족 TANF
- ○ 푸드 스탬프(Food Stamps) / SNAP
- ○ 저소득자 주택 에너지 지원 프로그램인 (LIHEAP)
- ○ 보조 사회보장 수입 (SSI)
- ○ 학교 무료 점심 프로그램(National School Lunch's FREE Lunch Program)
- ○ 인디언 업무 일반 보조국(Bureau of Indian Affairs General Assistance)
- ○ 헤드 스타트 소득 자격(Head Start Income Eligible) (인디언 부족만 해당)

○ **아니오** *(아니오인 경우 다음 질문사항을 계속하십시오)*▼

위에 나열된 어느 프로그램에도 등록되지 않으신 경우, 귀하의 연간 소득은 얼마입니까 (공제전, 모든 가족의 소득 포함)?►

○ $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

귀하의 소득원에 표시하십시오: ▼

- ○ 사회보장금
- ○ SSI 또는 SSDI
- ○ 연금
- ○ 저축, 주식, 채권, 또는 은퇴 구좌로부터의 이자 또는 배당금
- ○ 임금 그리고/또는 자영업 수익
- ○ 실업 혜택
- ○ 보험금 또는 법적 타협금
- ○ 장애 또는 산재 보상금
- ○ 배우자 또는 자녀 부양비
- ○ 장학금, 수여금, 또는 기타 생활 보조금
- ○ 임대료나 로열티 소득
- ○ 현금 또는 기타 소득

3

다음 사항에 동의하십니까? 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:** □□ / □□ / □□

Form 6674-C VI (09/09)

CHƯƠNG TRÌNH GIẢM GIÁ CỦA

A Sempra Energy utility

Kính Gởi Quý Khách Hàng: Ngày:

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

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

HOẶC

2. Gọi 1-866-716-3452 bất cứ lúc nào 24 giờ mỗi ngày, 7 ngày một tuần, và làm theo hướng dẫn để tái xác nhận qua điện thoại. Xin chuẩn bị sẵn sàng số trương mục của mình. Quý vị có thể tìm số trương mục này ở phần cuối của trang này,

HOẶC

3. Vào mạng của chúng tôi www.socalgas.com/care/recert/ và chuẩn bị sẵn số trương mục của quý vị.

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

CÁC CHƯƠNG TRÌNH TRỢ GIÚP CÔNG CỘNG:
Nếu quý vị hay người nào khác trong gia đình nhận trợ cấp từ bất cứ chương trình nào sau đây: Medicaid, Medi-Cal, Gia đình Khỏe mạnh loại A&B, Phụ nữ, Sơ sinh, & Trẻ em (WIC), TANF, Bản địa TANF, Chương trình Mầm non cho người có Lợi tức Hợp lệ (Chỉ dành cho Bản địa), Hỗ trợ Tổng quát của Văn phòng Sự vụ Da Đỏ (Bureau of Indian Affairs General Assistance), Food Stamps (SNAP), Chương trình Toàn quốc ăn Trưa Miễn phí tại Trường (NSL), Chương trình Trợ giúp Năng lượng cho Gia đình có Lợi tức Thấp (LIHEAP), Trợ Giúp An sinh Xã hội (SSI)

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH*:
(có hiệu lực từ ngày 1 tháng Sáu, 2009 đến 31 tháng Năm, 2010)
*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình

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
Thêm Mỗi người vào trong Gia Đình, 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
Tiếng 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:

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
Bôi đen đúng cách: ●

Form 6674-C VI (09/09)

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

1

Tên Khách Hàng:

Địa chỉ:

Số Trương Mục:

Điện Thoại Nhà #: (☐☐☐)☐☐☐-☐☐☐☐

Địa chỉ E-mail:

○ **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, chuyển thẳng sang câu 3 (●), **ký tên** ở dưới, và gởi mẫu đơn này trong phong bì đã trả trả buư phí được cung cấp sẵn trong vòng 90 ngày.*

2

Tổng số người trong hộ gia đình của quý vị: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ nếu có nhiều hơn 6: ☐

Quý vị (hoặc ai đó trong gia đình quý vị) có được hưởng bất cứ chương trình trợ giúp nào sau đây không?

○ **CÓ** *(Nếu có, xin bôi đen vào vòng tròn của (các) chương trình được hưởng, rồi chuyển sang câu 3)*▼

- ○ Medi-Cal: Dưới 65 tuổi
- ○ Medi-Cal: 65 tuổi
- ○ Gia Đình Khỏe Mạnh Loại A & B Chương Trình Phụ Nữ, Sơ Sinh và Trẻ Em (WIC)
- ○ Trợ Giúp Tạm Thời cho G Đnh có Nhu Câu (TANF) hoặc TANF Bản Địa
- ○ Phiếu Thực Phẩm
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Tribal Only

○ **KHÔNG** *(Nếu không, xin tiếp tục các câu sau)*►

Nếu quý vị không được hưởng bất cứ chương trình nào ở trên, mức lợi tức hàng năm của gia đình quý vị là bao nhiêu (lợi tức trước khi khấu trừ, bao gồm tất cả mọi người trong gia đình)? ▼

○ $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

Xin bôi đen vào vòng tròn của các nguồn lợi tức của quý vị: ▼

- ○ An sinh Xã hội
- ○ SSP, SSDI
- ○ Hưu bổng
- ○ Tiền Lời hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí
- ○ Lương và/hoặc Lợi tức Viêc Làm Tự do
- ○ Trợ cấp Thất nghiệp
- ○ Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định
- ○ Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm
- ○ Cấp dưỡng nuôi Con hoặc Phối ngẫu
- ○ Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống
- ○ Lợi tức cho Thuê hoặc Tiền Bản quyền
- ○ Lợi tức Tiền mặt hoặc Lợi tức Khác)

3

Quý vị có đồng ý với điều sau đây không? 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 cớ về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý 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 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. 6491-2C, 09/09) T

(See Attached Form)

The Gas Company

A Sempra Energy utility®

CARE 20% RATE DISCOUNT APPLICATION

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.

PLEASE COMPLETE IN BLACK OR DARK BLUE INK. CORRECT WAY TO MARK CIRCLES: ●

1

CUSTOMER NAME (AS IT APPEARS ON YOUR BILL):

HOME ADDRESS (STREET, APT #, CITY, ZIP):

ACCOUNT NUMBER:

SOURCE CODE:

PHONE NUMBER: – –

E-MAIL ADDRESS:

2

Total # of adults and children in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6:

Are you (or someone in your household) enrolled in any of the following assistance programs?

○ **YES** (If yes, mark the program(s) of participation, and go to question 3) ▼

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible – Tribal Only

○ **NO** (If no, please continue with the following questions) ▼

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)? ▼

○ $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

Please mark your sources of income: ▼

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, Grants, or Other Aid used for Living Expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Declaration: Please read and sign below.

I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform 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: / /

FORM 6491-2C EN 0709 ♻ Printed on recycled paper with soy-based inks. 0990083 0909 35M

The Gas Company

A Sempra Energy utility®

20% DISCOUNT CARE 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. The discount will be applied once your completed and signed application is approved by The Gas Company℠.

Please complete the application and return it in the envelope provided or apply online at ***www.socalgas.com/assistance/care/***

HOW 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/Medicaid
- Healthy Families Categories A & B
- Women, Infants, & Children (WIC)
- TANF or Tribal TANF
- Head Start Income Eligible – Tribal Only
- Bureau of Indian Affairs General Assistance (BIA GA)
- Food Stamps / SNAP
- National School Lunch's Free Lunch Program (NSL)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

← OR →

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	

* Includes current household income from all sources before deductions.

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:

Direct Assistance Program (DAP): Offers no-cost energy saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repairs to eligible low-income homeowners and renters. For more information, please call 1-800-331-7593.

Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

Low Income Home Energy Assistance Program (LIHEAP): Provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Dept. of Community Services and Development at 1-866-675-6623.

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

FOR MORE INFORMATION ON CUSTOMER ASSISTANCE:

English: 1-800-427-2200 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)

CONTRACTOR STAMP

The Gas Company
A Sempra Energy utility®

FORMULARIO DE SOLICITUD PARA EL DESCUENTO CARE DEL 20%

El programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company 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 nuevo servicio de gas también recibirán un descuento de $15 en el Cargo de Conexión de Servicio (Service Establishment Charge). El descuento se aplicará una vez que el formulario de solicitud debidamente llenado y firmado haya sido aprobado por The Gas Company℠.

Sírvase llenar el formulario de solicitud y regresarlo en el sobre provisto, o presentarlo en línea en ***www.socalgas.com/sp/asistencia/care/***

CÓMO CALIFICAR PARA EL DESCUENTO 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/Medicaid
- Familias Sanas Categorías A & B
- Programa de mujeres, infantes y niños (WIC)
- Asistencia temporal para familias necesitadas (TANF) o TANF tribal
- Elegible para ingreso de Ventaja Inicial – Solamente tribal
- Agencia de Asuntos Indios, Asistencia General (BIA GA)
- Programa de asistencia de nutrición suplementaria- cupones para alimentos/SNAP
- Programa de Almuerzo "National School Lunch's FREE" (NSL)
- Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- Ingreso Suplementario del Seguro Social (SSI)

O

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

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 TAL VEZ CALIFIQUE:

Programa de Asistencia Directa (DAP): Ofrece mejoras sin costo que ahorran energía en el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a inquilinos y propietarios con ingresos limitados que califiquen. 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.

El Programa de Ayuda Energética para Hogares de Bajos Ingresos (LIHEAP): Ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y protección de la casa contra los agentes atmosféricos. Llame al Departamento de Servicios a la Comunidad al 1-866-675-6623.

California Lifeline: 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 MÁS INFORMACIÓN ACERCA DE ASISTENCIA AL CLIENTE:

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/TTY): 1-800-252-0259
(disponible en inglés y español únicamente)

CONTRACTOR STAMP

The Gas Company

A Sempra Energy utility®

SOLICITUD CARE PARA UN 20% DE DESCUENTO

Para tener derecho al 20% de descuento en la tarifa de gas de su factura, 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.

POR FAVOR DE COMPLETAR EN TINTA NEGRA O AZUL OSCURA. FORMA CORRECTA DE MARCAR LOS CÍRCULOS: ●

1

NOMBRE DEL CLIENTE (TAL COMO APARECE EN SU FACTURA):

DOMICILIO PARTICULAR (CALLE, NO. DE APTO., CIUDAD, CÓDIGO POSTAL):

NÚMERO DE CUENTA: SOURCE CODE:

TELÉFONO: – –

CORREO ELECTRÓNICO:

2

Número total de adultos y niños que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6:

¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **SÍ** (Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3) ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial – Solamente tribal

○ **NO** (Si su respuesta es negativa, por favor continúe con las siguientes preguntas) ▼

Si no está inscrito actualmente en ninguno de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

○ $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 a l año

Por favor marque sus fuentes de ingreso: ▼

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o Indemnización para los trabajadores
- ○ Pensión conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

3

¿Acepta usted lo siguiente? Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar comprobantes de elegibilidad para CARE si se me solicita. 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: / /

 FORM 6491-2C SP 0709 ♻ Impreso en papel reciclado con tintas a base de soya. 0990083 0909 35M

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

(See Attached Form)

Form 6675-C EN (09/09)

IMMEDIATE REPLY NEEDED

A Sempra Energy utility®

Dear Customer: Date:

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:

Medicaid, Medi-Cal, Healthy Families A&B (Monthly Premium Statement), Women, Infants, & Children (WIC), TANF, Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, Food Stamps (SNAP), National School Lunch's Free Lunch Program (NSL), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

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 From 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 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 Verification Form

Please use DARK ink and print clearly to ensure proper processing

Correct way to mark circles: ●

Form 6675-C EN (09/09)

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

Customer Name (as it appears on your bill):

Home Address (street, city, ZIP):

Account Number:

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐

E-mail 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 go directly to #4, **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: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

(2) Please list names of everyone in your household (include you, additional adults, and children) and fill in the circle (●) to indicate whether each person is an adult or child.

	Name	Adult/Child			Name	Adult/Child	
1.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

Total Annual Household Income: If your household does not participate in any of the assistance programs from **List 1,** 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) ***YOU MUST PROVIDE PROOF THAT YOU QUALIFY FOR THIS PROGRAM***

I have **included** copies of documentation proving participation in an assistance program (list 1) **OR** income document(s) for every household member receiving income/aid (list 2). Please fill in a circle (●).

○ Yes ○ No

(4) **DECLARATION:** Please read and sign below.

I state that the information and documents I have provided in this application is true and correct. 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**: ☐☐ / ☐☐ / ☐☐

FOR SOCALGAS USE ONLY:

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

INC: $ ☐☐☐☐☐ HH: ☐☐ INITIALS: ☐☐

SE REQUIERE RESPUESTA INMEDIATA

Apreciable cliente: Fecha:

Actualmente recibe en la factura mensual de gas un descuento del 20% en la tarifa a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company. 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 o alguien que vive en su hogar recibe asistencia pública, **sírvase enviar la documentación que compruebe su participación** en cualquiera de los siguientes programas:

Medicaid / Medi-Cal, Familias Sanas Categorías A & B (Declaración de Prima Mensual)**, Programa para Mujeres, Infantes, y Niños (WIC), Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal, Cupones para alimentos / SNAP, Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP), Ingreso Suplementario del Seguro Social (SSI), Programa de Almuerzo "National School Lunch's FREE" (NSL), Agencia de Asuntos Indios, Asistencia General (BIA GA), Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal**

O

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 uno de los miembros que viva en su hogar y que reciba ingresos o ayuda**. El siguiente cuadro enlista las fuentes de ingreso y la documentación requerida:

Si usted recibe:	Documentación aceptable
Salarios, sueldos, propinas, comisiones	Los dos últimos talones de pago, o W2, o formulario 1040 del IRS
Seguro social, SSI, SSDI, pensiones, pagos por incapacidad, indemnización para los trabajadores, beneficios de desempleo	Constancias de beneficios, o copia del cheque, o estados de cuenta bancarios que muestren los depósitos, o formulario 1040 del IRS o formulario 1099 del IRS
Ingresos por 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 pólizas de seguro o convenios judiciales	Documentación relativa al pago de pólizas o convenios
Pensión alimenticia y/o conyugal	Documentación judicial o copia del cheque
Subvenciones, becas u otro tipo de ayuda escolar	Cartas de otorgamiento, o 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[SM] 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/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

Form 6675-C SP (09/09)

Verificación para la tarifa CARE del 20% de descuento

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

Forma correcta de marcar los círculos: ●

Nombre del cliente
(tal como aparece en su factura):

Domicilio particular:

Número de cuenta:

Teléfono: (☐☐☐)☐☐☐-☐☐☐☐

Dirección de correo electrónico:

○ **Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE.**
←*Si rellenó este círculo, por favor vaya directamente al número 4**, 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: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6: ☐

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

	Nombre	Adulto/Niño			Nombre	Adulto/Niño	
1.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

Ingreso total anual en el hogar: Si su hogar no participa en ninguno de los programas de asistencia de la **Lista 1**, sírvase marcar 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

DEBE PROPORCIONAR CONSTANCIA DE QUE REÚNE LOS REQUISITOS PARA ESTE PROGRAMA

(3) **Incluí** copias de la documentación que prueba la participación en un programa de asistencia (lista 1) **O** comprobante(s) de ingreso de cada miembro del hogar que recibe ingresos/ayuda (lista 2). Sírvase marcar 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.

Firma: X **Fecha**: ☐☐ / ☐☐ / ☐☐

PARA USO EXCLUSIVO DE SOCALGAS:

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

INC: $ ☐☐,☐☐☐ HH: ☐☐ INITIALS: ☐☐

Form 6675-C CH (09/09)

請立即答復

A Sempra Energy utility

親愛的客戶：　　日期:

您現在正通過 The Gas Company 的加州能源優惠 (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：**

Medicaid / Medi-Cal（加州醫療輔助計劃）、Supplemental Social Security（社會安全補助金）、Supplemental Nutrition Assistance Program （Food Stamps，食物券）、Healthy Families A&B（健康家庭低費兒童醫療健保計劃類別 A 及 B 每月保費報表)）、TANF（貧困家庭臨時現金資助計劃）、部落 TANF、WIC（婦女，嬰兒和兒童營養輔助計劃）、LIHEAP（低收入家庭能源協助計劃）、National School Lunch FREE Lunch Program（全國學童免費午餐計劃）、Bureau of Indian Affairs General Assistance（印第安事務局一般協助計劃）、Head Start Income Eligible – Tribal Only（部落學前教育補助金計劃）

或

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 ，加上 Schedule C 表格
租金、權利金收入	IRS 的 1040 表格，加上租金收入使用的 Schedule E 表格
儲蓄賬戶、退休賬戶、股票和債券中取得的利息或紅利	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
子女和/或配偶贍養費	法庭文件或支票副本
學校補助，獎學金或其它助學金	獲獎信件，兩份最近連續的輔助金支票存根（Pay Stubs），或支票副本
以上來源都不是	一份解釋您用於支撐家庭的收入來源的證明

若需更多關于 CARE 計劃的資訊，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
聽覺障礙專綫 (TDD/TTY): 1-800-252-0259（僅提供英語和西班牙語服務）

Form 6675-C CH (09/09)

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）

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

客戶姓名：

地址：

帳戶號碼：

聯絡電話：（□□□）□□□-□□□□

電郵地址：

○ **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(●)，請直接填写第 **4** 部分，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： ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 如果超過 6: □

(2) 請列出您家庭中每位成員的姓名（包括您本人，其他成年人和兒童），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.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

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，請您把能體現您家庭收入範圍的圓圈塗黑(●)。

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

○ 如果多于 $58,000，請在此處填寫金額： $ □□,□□□.00 每年

(3) ***您必須提供證明您符合參加本計劃資格的資料***

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**/**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。

我聲明在此申請中提供的資料和文件均正確屬實。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它的公用事業公司或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: □□

Form 6675-C KO (09/09)

즉시 회신하셔야 합니다

친애하는 고객님: 날짜:

귀하께서는 현재 The Gas Company 의 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 90 일 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.**

메디케이드(Medicaid) , Medi-Cal, 건강한 가족 유형 A 및 B (Healthy Families A&B) (월 보험료 명세서),
여성, 유아 및 어린이 (Women, Infants and Children WIC), TANF 또는 부족 TANF,
헤드 스타트 소득 자격 (Head Start Income Eligible – Tribal Only) (인디언 부족만 해당),
인디언 업무 일반 보조국(Bureau of Indian Affairs General Assistance),
푸드 스탬프(Food Stamps, SNAP), 학교 무료 점심 프로그램 (National School Lunch's Free Lunch Program, NSL),
저소득 주택 에너지 지원 프로그램 (Low Income Home Energy Assistance Program, LIHEAP),
추가 사회보장 수입 (Supplemental Security Income, SSI)

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, 법적 타협금	타협 문서
자녀 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 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 확인 양식

정확히 처리되도록 하기 위해 진한 펜을 사용하여 분명히 인쇄체로 기입
동그라미에 바르게 표시하는 방법: ●

Form 6675-C KO (09/09)

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

고객 이름:

주소:

구좌 번호:

주택 전화번호: (□□□)□□□-□□□□

이메일 주소:

○ **본인은 더 이상 자격이 없거나 CARE 에 참여하기를 원치 않습니다. 본인의 구좌를 CARE 프로그램에서 삭제하십시오.**
←이 동그라미(●) 안을 채운 경우, 직접 **4** 번으로 가서 하단에 **서명하여** 이 양식을 제공된 우송료 선불 봉투에 넣어 **90** 일 내에 우송하십시오.

(1) 귀 가구의 총 식구 수 (귀하, 다른 성인 및 어린이 포함): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 만약 6 개 이상: □

(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.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

총 연간 가구 소득: 목록 1 에 나열된 어느 프로그램에도 참여하지 않으시는 경우, 공제전 귀하 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

(3) ***귀하는 본 프 로그램 수혜 자격이 있다는 증명서류를 제출해야 합니다***
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 사실이고 정확함을 진술합니다. 본인이 할인을 받을 자격이 더 이상 없게 될 경우 The Gas Company 에 통보하기로 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수도 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**: □□ / □□ / □□

SOCALGAS 에 한하여서만 사용 :

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

INC: $ □□□□□ HH: □□ INITIALS: □□

Form 6675-C VI (09/09)

CẦN HỒI ĐÁP NGAY

Kính Gởi Quý Khách Hàng: Ngày:

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 California (California Alternate Rates for Energy hay CARE) của The Gas Company. 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 gởi lại mẫu đơn điền đầy đủ và ký tên bao gồm cả (các) tài liệu được yêu cầu trong phong bì 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 gởi tài liệu xác nhận được hưởng** bất cứ chương trình nào sau đây:

Medicaid, Medi-Cal, Gia đình Khỏe mạnh loại A&B (Bản kê Phí bảo hiểm Hàng tháng), Phụ nữ, Sơ sinh, & Trẻ em (WIC), TANF, Bản địa TANF, Chương trình Mầm non cho người có Lợi tức Hợp lệ (Chỉ dành cho Bản địa), Hỗ trợ Tổng quát của Văn phòng Sự vụ Da Đỏ (Bureau of Indian Affairs General Assistance), Food Stamps (SNAP), Chương trình Toàn quốc ăn Trưa Miễn phí tại Trường (NSL), Chương trình Trợ giúp Năng lượng cho Gia đình có Lợi tức Thấp (LIHEAP), Trợ Giúp An sinh Xã hội (SSI)

HOẶC

Danh sách 2) Nếu không có ai trong gia đình của quý vị được hưởng bất cứ chương trình nào ở trên, **xin gởi bản sao các tài liệu về lợi tức của mọi thành viên trong 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 Lương liên tục gần đây nhất, hay mẫu đơn W2, hoặc mẫu 1040 IRS
An Sinh Xã Hội, SSI, SSDI, Hưu Bổng, Trợ Cấp Tàn Phế, Bồi Thường Lao Động, Trợ Cấp Thất Nghiệp	Bản Kê Quyền Lợi, hay Bản Sao Chi Phiếu, hoặc Bản Kê Trương Mục Ngân Hàng về khoản tiền ký thác, hoặc Mẫu Đơn 1040 IRS, hoặc Mẫu Đơn 1099 IRS
Lợi Nhuận Việc Làm Tự Do	Mẫu Đơn 1040 IRS, cùng với Liệt Kê C
Lợi Tức Cho Thuê, Lợi Tức Bản Quyền	Mẫu Đơn 1040 IRS, cùng với Liệt Kê E về lợi tức cho thuê
Tiền Lời hay Cổ Tức từ Trương Mục Tiết Kiệm, Hưu Trí, Cổ Phiếu, Trái Phiếu	Mẫu Đơn 1040 IRS, hay (các) Mẫu Đơn 1099 IRS
Bảo Hiểm, Thỏa Hiệp Pháp Định	Tài Liệu về Thỏa Hiệp Pháp Định
Tiền Nuôi Con và/hoặc Phối Ngẫu	Tài Liệu Toà Án, hay Bản Sao Chi Phiếu
Tài Trợ Học Hành, Học Bổng, hay Trợ Giúp Khác	Thư Tài Trợ, hoặc hai cùi lương liên tục gần đây nhất, hay Bản Sao Chi Phiếu
Không có Nguồn Nào nêu Trên	Một bản kê giải thích các nguồn lợi tức dùng cho gia đình quý vị

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

Tiếng Anh: 1-800-427-2200 Quan Thoại: 1-800-427-1429 Tây Ban Nha: 1-800-342-4545
Tiếng 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 bằng tiếng Anh và Tây Ban Nha)

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

Form 6675-C VI (09/09)

Xin dùng mực đậm và viết bằng chữ in để đảm bảo xét duyệt chính xác
Bôi đen đúng cách: ●

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

Tên Khách Hàng:

Địa chỉ:

Số Trương Mục:

Điện Thoại Nhà #: (□□□)□□□-□□□□

Địa chỉ E-mail:

○ **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, chuyển thẳng sang câu 4 (●),* ***ký tên*** *ở dưới, và gởi mẫu đơn này trong phong bì đã trả trả buư phí được cung cấp sẵn trong vòng 90 ngày.*

(1) Tổng số người trong hộ gia đình của quý vị: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ nếu có nhiều hơn 6: □

(2) Xin ghi tên mọi người trong 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.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

Nếu quý vị không được hưởng bất cứ chương trình nào ở trên, mức lợi tức hàng năm của gia đình quý vị là bao nhiêu (lợi tức trước khi khấu trừ, bao gồm tất cả mọi người trong gia đình)?

○ $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) ***QUÝ VỊ PHẢI CUNG CẤP TÀI LIỆU CHỨNG MINH LÀ QUÝ VỊ HỘI ĐỦ ĐIỀU KIỆN THAM GIA CHƯƠNG TRÌNH NÀY***
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 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 và tài liệu tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý 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 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-C, 09/09) T

(See Attached Form)

Form 6677-C EN (09/09)

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY

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 Company[SM], 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.

Or apply online at http://www.socalgas.com/assistance/care/

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:

If you or someone in your household participates in any of these programs:
Medicaid, Medi-Cal, Healthy Families A&B,
Women, Infants, & Children (WIC),
TANF, Tribal TANF,
Head Start Income Eligible - Tribal Only,
Bureau of Indian Affairs General Assistance,
Food Stamps (SNAP),
National School Lunch's Free Lunch Program (NSL),
Low Income Home Energy Assistance Program (LIHEAP),
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2009 to May 31, 2010)
*current household income from all sources before deductions

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 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 - Offers free energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repair to eligible low-income home-owners and renters. For more information, please call 1-800-331-7593.

Medical Baseline - Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

LIHEAP – Low Income Home Energy Assistance Program provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Dept. of Community Services and Development at 1-866-675-6623.

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

FOR 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
Correct way to mark circles: ●

Form 6677-C EN (09/09)

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

1

Customer Name (as it appears on your bill):

Home Address (street, space #, city, ZIP):

Facility ID:

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐

E-mail Address:

2

Total # of adults and children in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

Are you (or someone in your household) enrolled in any of the following assistance programs?

○ **YES** *(If yes, mark the program(s) of participation, and go to question 3)*▼

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **NO** *(If No, please continue with following questions)*►

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)?▼

○ $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

Please mark your sources of income: ▼

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, grants, or other aid used for living expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Do you agree to the following? 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:** ☐☐ / ☐☐ / ☐☐

Form 6677-C SP (09/09)

FORMULARIO DE SOLICITUD PARA EL DESCUENTO CARE DEL 20%

EL PROGRAMA DE TARIFAS ALTERNAS PARA ENERGÍA EN CALIFORNIA

El programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company 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.

O presente su formulario en-línea en www.socalgas.com/sp/asistencia/care/.

CÓMO CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:

Medicaid/Medi-Cal, Familias Sanas Categorías A & B,
Programa para Mujeres, Infantes, y Niños (WIC),
Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal,
Cupones para alimentos / SNAP,
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP),
Ingreso Suplementario del Seguro Social (SSI),
Programa de Almuerzo "National School Lunch's FREE" (NSL),
Agencia de Asuntos Indios, Asistencia General (BIA GA),
Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

O

INGRESO MÁXIMO EN EL HOGAR:
(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

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.

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE TAL VEZ CALIFIQUE:

DAP: El Programa de Asistencia Directa, un programa de eficiencia energética para clientes de bajos recursos, ofrece mejoras gratuitas para ahorrar energía en el hogar, tales como aislamiento de techo, colocación de burletes para puertas, enmasillado y reparaciones menores a la casa. 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.

LIHEAP: El Programa de Ayuda Energética para Hogares de Bajos Recursos ofrece asistencia para el pago de facturas, asistencia de emergencia para el pago de facturas y protección de la casa contra los agentes atmosféricos. Llame al Departamento de Servicios a la Comunidad al 1-866-675-6623.

California Lifeline: 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/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

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

Form 6677-C SP (09/09)

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

Forma correcta de marcar los círculos: ●

1

Nombre del cliente (tal como aparece en su factura):

Domicilio particular:

Número de complejo habitacional:

Teléfono: (☐☐☐)☐☐☐-☐☐☐☐

Dirección de correo electrónico:

2

Número total de adultos y niños que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6: ☐

¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **Sí** *(Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3)* ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes, y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

○ **No** *(Si su respuesta es negativa, por favor continúe con las siguientes preguntas)*►

Si no está inscrito actualmente en ninguno de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

○ $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

Por favor marque sus fuentes de ingreso: ▼

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o Indemnización para los trabajadores
- ○ Pensión conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

3

¿Acepta usted lo siguiente? Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar comprobantes de elegibilidad para CARE si se me solicita. 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** : ☐☐ / ☐☐ / ☐☐

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

(See Attached Form)

Form 6678-C EN (09/09)

YOUR RATE DISCOUNT IS EXPIRING

Dear Customer: Date:

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 your completed and signed Recertification 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 someone in your household participates in any of these programs: Medicaid, Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC), TANF, Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, Food Stamps (SNAP), National School Lunch's Free Lunch Program (NSL), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME:
(effective June 1, 2009 to May 31, 2010)
*current household income from all sources before deductions

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 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.

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:

CARE 20% Rate Discount Recertification Form

Please use DARK ink and print clearly to ensure proper processing

Correct way to mark circles: ●

Form 6678-C EN (09/09)

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

1

Customer Name (as it appears on your bill):

Home Address (street, space #, city, ZIP):

Facility ID:

Phone Number: (☐☐☐)☐☐☐-☐☐☐☐

E-mail 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 go directly to #3, **sign** at the bottom, and mail this form in the postage paid envelope provided within 90 days.*

2

Total # of adults and children in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

Are you (or someone in your household) enrolled in any of the following assistance programs?

○ **YES** *(If yes, mark the program(s) of participation, and go to question 3)*▼

- ○ Medi-Cal / Medicaid: Under Age 65
- ○ Medi-Cal / Medicaid: 65 or older
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only

○ **NO** *(If No, please continue with following questions)*►

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)?▼

○ $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

Please mark your sources of income: ▼

- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child Support
- ○ Scholarships, grants, or other aid used for living expenses
- ○ Rental or Royalty Income
- ○ Cash or Other Income

3

Do you agree to the following? 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:** ☐☐ / ☐☐ / ☐☐

Form 6678-C SP (09/09)

EL DESCUENTO EN SU TARIFA ESTÁ POR VENCER

Apreciable cliente: Fecha:

Actualmente recibe en la factura mensual de gas un descuento del 20% en la tarifa a través del programa de Tarifas Alternas para Energía en California (CARE) de The Gas Company. 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 dos 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 www.socalgas.com/care/recert/ y tenga listo el número de complejo habitacional (*Facility ID*).

HAY DOS FORMAS DE CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:

Si usted o alguien que vive en su hogar participa en cualquiera de estos programas:

Medicaid/Medi-Cal, Familias Sanas Categorías A & B,
Programa para Mujeres, Infantes, y Niños (WIC),
Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal,
Cupones para alimentos / SNAP
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa de Almuerzo "National School Lunch's FREE" (NSL)
Agencia de Asuntos Indios, Asistencia General (BIA GA)
Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

O

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2009 al 31 de mayo de 2010)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

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 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/TTY): 1-800-252-0259 (disponible en inglés y español únicamente)

Número de complejo habitacional (*Facility ID)*:

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

Form 6678-C SP (09/09)

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
Forma correcta de marcar los círculos: ●

1

Nombre del cliente (tal como aparece en su factura):

Domicilio particular:

Número de complejo habitacional:

Teléfono: (___)___-____

Dirección de correo electrónico:

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

2

Número total de adultos y niños que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ si más de 6: ___

¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **Sí** *(Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3)* ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Familias Sanas Categorías A & B
- ○ Programa para Mujeres, Infantes, y Niños (WIC)
- ○ Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal
- ○ Cupones para alimentos / SNAP
- ○ Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa de Almuerzo "National School Lunch's FREE (NSL)
- ○ Agencia de Asuntos Indios, Asistencia General (BIA GA)
- ○ Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

○ **No** *(Si su respuesta es negativa, por favor continúe con las siguientes preguntas)*►

Si no está inscrito actualmente en ninguno de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

○ $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

Por favor marque sus fuentes de ingreso: ▼

- ○ Seguro Social
- ○ SSP o SSDI
- ○ Pensiones
- ○ Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Salarios y/o ingresos de autoempleo
- ○ Beneficios de desempleo
- ○ Pagos de pólizas de seguro o convenios judiciales
- ○ Pagos por incapacidad o Indemnización para los trabajadores
- ○ Pensión conyugal o alimenticia
- ○ Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Ingresos por alquiler o regalías
- ○ Dinero en efectivo y/u otros ingresos

3

¿Acepta usted lo siguiente? Por favor lea y firme abajo.

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar comprobantes de elegibilidad para CARE si se me solicita. 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** : __ / __ / __

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

(See Attached Form)

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

The Gas Company
A Sempra Energy utility®

The Gas Company
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 RECIENTEMENTE DESEMPLEADO USTED TAMBIÉN PODRÍA 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 APLIQUE 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 Company℠. 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 Company℠. 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

Printed on recycled paper with soy-based inks.
G09-3041 0990084 0909 XM

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

Direct Assistance Program (DAP): Offers no-cost energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repairs to eligible low-income homeowners and renters. For more information, please call 1-800-331-7593.

Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

Low Income Home Energy Assistance Program (LIHEAP): Provides bill payment assistance, emergency bill assistance and weatherization services. Call the California Department of Community Services and Development at 1-866-675-6623.

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

OTROS PROGRAMAS Y SERVICIOS PARA LOS QUE PODRÍA CALIFICAR:

Programa de Asistencia Directa (DAP): Ofrece mejoras sin costo que ahorran energía en el hogar, tales como aislamiento de techo, colocación de burletes en puertas, enmasillado y reparaciones menores, a inquilinos y propietarios con ingresos limitados que califiquen. 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 médicas. 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): Acceso telefónico a precios de descuento para los clientes que reúnan requisitos de ingresos 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/Medicaid
- Healthy Families Categories A & B
- Women, Infants, & Children (WIC)
- TANF or/o Tribal TANF
- Head Start Income Eligible – Tribal Only/Solamente tribal
- Bureau of Indian Affairs General Assistance (BIA GA)
- Food Stamps / SNAP
- National School Lunch's Free Lunch Program (NSL)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

←OR/O→

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

*Includes current household income from all sources before deductions
*Incluye los ingresos actuales del hogar de todas las fuentes de ingreso antes de deducciones

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.

CUSTOMER NAME/NOMBRE DEL CLIENTE (FIRST AND LAST AS IT APPEARS ON YOUR BILL/NOMBRE(S) Y APELLIDO COMO APARECE EN SU FACTURA)

ADDRESS/DOMICILIO

APT #/NO. DE APTO.

CITY/CIUDAD

HOME PHONE/TELÉFONO DE SU CASA

EMAIL/CORREO ELECTRÓNICO:

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):

○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ **If more than 6: si mas de 6:**

2

Are you (or someone in your household) enrolled in any of the following assistance programs?
¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?

○ **YES (If yes, please fill in the circle(s) ●, and go directly to 3.)**
SÍ (Si su respuesta es afirmativa, por favor rellene el/los círculo/s ●, y vaya directamente a la sección 3.)

- ○ Medi-Cal / Medicaid: Under Age 65/menor de 65 años
- ○ Medi-Cal / Medicaid: 65 or older/65 años o más
- ○ Healthy Families Categories A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ Temporary Assistance for Needy Families (TANF) or Tribal TANF
- ○ Food Stamps / SNAP
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch's FREE Lunch Program (NSL)
- ○ Bureau of Indian Affairs General Assistance (BIA GA)
- ○ Head Start Income Eligible - Tribal Only/Solamente tribal

○ **NO (if no, please continue with the following questions)**
NO (si su respuesta es negativa, por favor continúe con las siguientes preguntas)

If you are not currently enrolled in any of the programs above, what is your yearly household income (before deductions, including all members of the household)? / Si no está inscrito actualmente en ningún de los programas que aparecen en la lista anterior, ¿cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)?

○ $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

Please mark your sources of income / Por favor marque sus fuentes de ingreso

- ○ Social Security/Seguro Social
- ○ SSP or SSDI/SSP o SSDI
- ○ Pensions/Pensiones
- ○ Interest or Dividends from Savings, Stocks, Bonds, or Retirement Accounts/Intereses o dividendos de cuentas de ahorro, acciones, bonos, o cuentas para el retiro
- ○ Wages and/or Profit from Self Employment/Salarios y/o ingresos de autoempleo
- ○ Unemployment Benefits/Beneficios de desempleo
- ○ Insurance or Legal Settlements/Pagos de pólizas de seguro o convenios judiciales
- ○ Disability or Workers Compensation Payments/Pagos por incapacidad o indemnización para los trabajadores
- ○ Spousal or Child Support/Pension conyugal o alimenticia
- ○ Scholarships, Grants, or Other Aid used for Living Expenses /Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
- ○ Rental or Royalty Income/Ingresos por alquiler o regalías
- ○ Cash or Other Income/Dinero en efectivo y/u otros ingresos

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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 / /

FORM 6491-BI 0909

No Tape/*No use cinta adhesiva* | Moisten and Seal/*Humedezca y selle* | No Staples/No engrape

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SAMPLE FORMS

Applications

Receipts and Notices

Surety or Guarantee for Account

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The following listed sheets contain all effective Schedules of Rates and Rules affecting service and information relating thereto in effect on the date indicated thereon.

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