

PUBLIC UTILITIES COMMISSION

505 VAN NESS AVENUE
SAN FRANCISCO, CA 94102-3298



July 1, 2010

Advice Letter 4111

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

Subject: Revision of the Income-Eligibility Guidelines, and Submission of Revised Application Forms and Instructions for the California Alternate Rates for Energy (CARE) Program

Dear Mr. van der Leeden:

Advice Letter 4111 is effective June 1, 2010.

Sincerely,

A handwritten signature in blue ink that reads "Julie A. Fitch".

Julie A. Fitch, Director
Energy Division



Rasha Prince
Director
Regulatory Affairs

555 W. Fifth Street, GT14D6
Los Angeles, CA 90013-1011
Tel: 213.244.5141
Fax: 213.244.4957
RPrince@semprautilities.com

May 14, 2010

Advice No. 4111
(U 904 G)

Public Utilities Commission of the State of California

Subject: Revision of the Income-Eligibility Guidelines, and Submission of Revised Application Forms and Instructions for the California Alternate Rates for Energy (CARE) Program

Southern California Gas Company (SoCalGas) hereby submits for filing with the California Public Utilities Commission (Commission) 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' income-qualified rate schedules to reflect the increased income-eligibility guidelines used to qualify individuals or households for the California Alternate Rates for Energy (CARE) program. The Energy Division has determined that the new income levels are increased by 2.7% and rounded to the nearest 100. This filing revises the application instructions and forms to reflect the revised income guidelines and categorical eligibility public assistance programs. Furthermore, the forms reflect the name change of one of the public assistance programs. National School Lunch's Free Lunch Program (NSL) has been changed to National School Lunch Program (NSLP) to be consistent with the California Department of Education and the United States Department of Agriculture (USDA). This filing contains 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.

Information

Res. E-3524 authorizes the energy utilities to change the income-eligibility guidelines for the CARE program pursuant to a communication issued by the Director of the Energy

Division by May 1st of each year, with tariff revisions to be filed and become effective June 1st of each year.

Pursuant to a notice dated April 23, 2010, from the Director of the Energy Division, SoCalGas was provided with the new CARE income-eligibility levels to be effective from June 1, 2010, through May 31, 2011. This notice further directs the energy utilities to file revised tariffs with the Energy Division reflecting the new income levels by May 14, 2010.

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, which is June 3, 2010. 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 (inj@cpuc.ca.gov) of the Energy Division. A copy of the protest should also be sent via both e-mail and facsimile to the address shown below on the same date it is mailed or delivered to the Commission.

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

Effective Date

SoCalGas believes that this filing is subject to Energy Division disposition and should be classified as Tier 1 (effective pending disposition) pursuant to GO 96-B. In compliance with OP 3 of Res. E-3524, dated February 19, 1998, and the April 23, 2010 notice from the Energy Division, the tariff sheets filed herein are to be effective for service on and after June 1, 2010.

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.

Rasha Prince
Director – Regulatory Affairs

Attachments

CALIFORNIA PUBLIC UTILITIES COMMISSION

ADVICE LETTER FILING SUMMARY ENERGY UTILITY

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

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

Utility type:

ELC GAS
 PLC HEAT WATER

Contact Person: Sid Newsom

Phone #: (213) 244-2846

E-mail: snewsom@semprautilities.com

EXPLANATION OF UTILITY TYPE

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

(Date Filed/ Received Stamp by CPUC)

Advice Letter (AL) #: 4111

Subject of AL: Revision of the Income-Eligibility Guidelines, and Submission of Revised Application Forms and Instructions for the California Alternate Rates for Energy (CARE) Program

Keywords (choose from CPUC listing): CARE, Forms

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

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

E-3524

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

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

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

Resolution Required? Yes No

Tier Designation: 1 2 3

Requested effective date: June 1, 2010

No. of tariff sheets: 17

Estimated system annual revenue effect (%): None

Estimated system average rate effect (%): None

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

Tariff schedules affected: Sample Forms and TOCs

Service affected and changes proposed¹: N/A

Pending advice letters that revise the same tariff sheets: _____

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

CPUC, Energy Division

Attention: Tariff Unit

505 Van Ness Ave.

San Francisco, CA 94102

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

Southern California Gas Company

Attention: Sid Newsom

555 West Fifth Street, GT14D6

Los Angeles, CA 90013-1011

snewsom@semprautilities.com

¹ Discuss in AL if more space is needed.

ATTACHMENT A

Advice No. 4111

(See Attached Service List)

Alcantar & Kahl
Kari Harteloo
klc@a-klaw.com

Alcantar & Kahl
Seema Srinivasan
sls@a-klaw.com

Alcantar & Kahl LLP
Annie Stange
sas@a-klaw.com

Alcantar & Kahl, LLP
Mike Cade
wmc@a-klaw.com

Barkovich & Yap
Catherine E. Yap
ceyap@earthlink.net

Beta Consulting
John Burkholder
burkee@cts.com

CPUC
Consumer Affairs Branch
505 Van Ness Ave., #2003
San Francisco, CA 94102

CPUC
Energy Rate Design & Econ.
505 Van Ness Ave., Rm. 4002
San Francisco, CA 94102

CPUC
Pearlie Sabino
pzs@cpuc.ca.gov

CPUC - DRA
Jacqueline Greig
jnm@cpuc.ca.gov

CPUC - DRA
Galen Dunham
gsd@cpuc.ca.gov

CPUC - DRA
R. Mark Pocta
rmp@cpuc.ca.gov

California Energy Commission
Randy Roesser
rroesser@energy.state.ca.us

California Energy Market
Lulu Weinzimer
luluw@newsdata.com

Calpine Corp
Avis Clark
aclark@calpine.com

City of Azusa
Light & Power Dept.
215 E. Foothill Blvd.
Azusa, CA 91702

City of Banning
Paul Toor
P. O. Box 998
Banning, CA 92220

City of Burbank
Fred Fletcher/Ronald Davis
164 West Magnolia Blvd., Box 631
Burbank, CA 91503-0631

City of Colton
Thomas K. Clarke
650 N. La Cadena Drive
Colton, CA 92324

City of Long Beach, Gas & Oil Dept.
Chris Garner
2400 East Spring Street
Long Beach, CA 90806

City of Los Angeles
City Attorney
200 North Main Street, 800
Los Angeles, CA 90012

City of Pasadena - Water and Power
Dept.
G Bawa
GBawa@cityofpasadena.net

City of Riverside
Joanne Snowden
jsnowden@riversideca.gov

City of Vernon
Dan Bergmann
dan@igservice.com

Commerce Energy
Catherine Sullivan
csullivan@commerceenergy.com

Commerce Energy
Blake Lazusso
blasuzzo@commerceenergy.com

County of Los Angeles
Stephen Crouch
1100 N. Eastern Ave., Room 300
Los Angeles, CA 90063

Crossborder Energy
Tom Beach
tomb@crossborderenergy.com

Culver City Utilities
Heustace Lewis
Heustace.Lewis@culvercity.org

DGS
Henry Nanjo
Henry.Nanjo@dgs.ca.gov

Davis Wright Tremaine, LLP
Edward W. O'Neill
505 Montgomery Street, Ste 800
San Francisco, CA 94111

Davis, Wright, Tremaine
Judy Pau
judypau@dwt.com

Dept. of General Services
Celia Torres
celia.torres@dgs.ca.gov

Douglass & Liddell
Dan Douglass
douglass@energyattorney.com

Douglass & Liddell
Donald C. Liddell
liddell@energyattorney.com

Downey, Brand, Seymour & Rohwer
Dan Carroll
dcarroll@downeybrand.com

Dynegy
Mark Mickelson
Mark.Mickelson@dynegy.com

Dynegy - West Generation
Joseph M. Paul
Joe.Paul@dynegy.com

Gas Transmission Northwest
Corporation
Bevin Hong
Bevin_Hong@transcanada.com

General Services Administration
Facilities Management (9PM-FT)
450 Golden Gate Ave.
San Francisco, CA 94102-3611

Goodin, MacBride, Squeri, Ritchie &
Day, LLP
J. H. Patrick
hpatrick@gmssr.com

Goodin, MacBride, Squeri, Ritchie &
Day, LLP
James D. Squeri
jsqueri@gmssr.com

Hanna & Morton
Norman A. Pedersen, Esq.
npedersen@hanmor.com

Imperial Irrigation District
K. S. Noller
P. O. Box 937
Imperial, CA 92251

JBS Energy
Jeff Nahigian
jeff@jbsenergy.com

Kern River Gas Transmission Company
Janie Nielsen
Janie.Nielsen@KernRiverGas.com

LA County Metro
Julie Close
closeJ@metro.net

LADWP
Robert Pettinato
Robert.Pettinato@ladwp.com

LADWP
Nevenka Ubavich
nevenka.ubavich@ladwp.com

Law Offices of William H. Booth
William Booth
wbooth@booth-law.com

Megan Lawson
MEHR@PGE.COM

Luce, Forward, Hamilton & Scripps
John Leslie
jleslie@luce.com

MRW & Associates
Robert Weisenmiller
mrw@mrwassoc.com

Manatt Phelps Phillips
Randy Keen
rkeen@manatt.com

Manatt, Phelps & Phillips, LLP
David Huard
dhuard@manatt.com

March Joint Powers Authority
Lori Stone
23555 Meyer Drive,
March Air Reserve Base, CA 92518-
2038

Julie Morris
Julie.Morris@PPMEnergy.com

National Utility Service, Inc.
Jim Boyle
One Maynard Drive, P. O. Box 712
Park Ridge, NJ 07656-0712

Navigant Consulting, Inc.
Ray Welch
ray.welch@navigantconsulting.com

PG&E Tariffs
Pacific Gas and Electric
PGETariffs@pge.com

Praxair Inc
Rick Noger
rick_noger@praxair.com

Regulatory & Cogen Services, Inc.
Donald W. Schoenbeck
900 Washington Street, #780
Vancouver, WA 98660

Safeway, Inc
Cathy Ikeuchi
cathy.ikeuchi@safeway.com

Sempra Global
William Tobin
wtobin@sempraglobal.com

Sierra Pacific Company
Christopher A. Hilén
chilen@sppc.com

Southern California Edison Co
Fileroom Supervisor
2244 Walnut Grove Av, 290, GO1
Rosemead, CA 91770

Southern California Edison Co
Karyn Gansecki
601 Van Ness Ave., #2040
San Francisco, CA 94102

Southern California Edison Co.
Kevin Cini
Kevin.Cini@SCE.com

Southern California Edison Co.
John Quinlan
john.quinlan@sce.com

Southern California Edison Co.
Colin E. Cushnie
Colin.Cushnie@SCE.com

Southern California Edison Company
Michael Alexander
Michael.Alexander@sce.com

Southwest Gas Corp.
John Hester
P. O. Box 98510
Las Vegas, NV 89193-8510

Suburban Water System
Bob Kelly
1211 E. Center Court Drive
Covina, CA 91724

Sutherland, Asbill & Brennan
Keith McCrea
kmccrea@sablaw.com

TURN
Mike Florio
mflorio@turn.org

TURN
Marcel Hawiger
marcel@turn.org

The Mehle Law Firm PLLC
Colette B. Mehle
cmehle@mehlelaw.com

Western Manufactured Housing
Communities Assoc.
Sheila Day
sheila@wma.org

ASSERT INC.
ELISABETH ADAMS
 eadams.assert@verizon.net

CALIF PUBLIC UTILITIES COMMISSION
Zaida Amaya-Pineda
 zca@cpuc.ca.gov

CALCERTS,, INC.
MICHAEL E. BACHAND
 mike@calcerts.com

SAN DIEGO GAS & ELECTRIC/SOCAL GAS
GEORGETTA J. BAKER
 GBaker@SempraUtilities.com

RESIDENTIAL WALL INSULATION
CRISTAL BEDORTHA
 cristalfour@aol.com

CALIFORNIA ENERGY COMMISSION
SYLVIA BENDER
 sbender@energy.state.ca.us

BRAUN BLAISING MCLAUGHLIN P.C.
SCOTT BLAISING
 blaising@braunlegal.com

THE DOLPHIN GROUP
MICHAEL BOCCADORO
 mboccadoro@dolphingroup.org

BRAUN BLAISING MCLAUGHLIN, P.C.
C. ANTHONY BRAUN
 braun@braunlegal.com

RICHARD HEATH AND ASSOCIATES, INC.
ART BRICE
 abrace@rhainc.com

CALIFORNIA URBAN WATER CONSERVATION
CHRIS BROWN
 chris@cuwcc.org

A WORLD INSTITUTE FOR SUSTAINABLE HUMANI
SUSAN E. BROWN
 sebesq@comcast.net

INSULATION CONTRACTORS ASSN.
ROBERT E. BURT
 4153 NORTHGATE BLVD., NO.6
 SACRAMENTO, CA 95834

CITY OF SAN DIEGO
MICHAEL P. CALABRESE
OFFICE OF THE CITY ATTORNEY
 1200 THIRD AVENUE, SUITE 1100
 SAN DIEGO, CA 92101

CALIFORNIA STATE UNIVERSITY, FRESNO
PETER CANESSA
 pcanessa@charter.net

PACIFIC GAS AND ELECTRIC COMPANY
DANIEL COOLEY
 dfc2@pge.com

SOUTHERN CALIFORNIA EDISON COMPANY
LARRY COPE
 larry.cope@sce.com

CALIFORNIA CONSERVATION CORPS
PATRICK COUCH
 patrick.couch@ccc.ca.gov

CAROLYN COX
 carolyncox2@sbcglobal.net

MCR PERFORMANCE SOLUTIONS
THOMAS S. CROOKS
 tcrooks@mcr-group.com

WEST COAST GAS COMPANY
RAYMOND J. CZAHAR, C.P.A.
 westgas@aol.com

CALIF PUBLIC UTILITIES COMMISSION
Jeanne Clinton
 cln@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Michael Colvin
 mc3@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Cheryl Cox
 cxc@cpuc.ca.gov

GOODIN MACBRIDE SQUERI DAY & LAMPREY LLP
MICHAEL B. DAY
 mday@goodinmacbride.com

MOUNTAIN UTILITIES
JOHN DUTCHER
 ralf1241a@cs.com

CALIF PUBLIC UTILITIES COMMISSION
Tim G. Drew
 zap@cpuc.ca.gov

CAL - UCONS, INC.
THOMAS ECKHART
 tom@ucons.com

SESCO, INC.
RICHARD ESTEVES
 sesco@optonline.net

NATURAL RESOURCES DEFENSE COUNCIL
LARA ETTENSON
 lettenson@nrdc.org

CHARTER COMMUNICATIONS
SUSAN EVANS
 5797 EASTSIDE RD
 REDDING, CA 96001

ATKINSON, ANDELSON, LOYA, RUUD & ROMO
ROBERT FRIED
 5776 STONERIDGE MALL ROAD, STE 200
 PLEASANTON, CA 94588

CALIF PUBLIC UTILITIES COMMISSION
Cathleen A. Fogel
 cf1@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Jamie Fordyce
 jbf@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Hazlyn Fortune
 hcf@cpuc.ca.gov

LATINO ISSUES FORUM
ENRIQUE GALLARDO
 160 PINE STREET, SUITE 700
 SAN FRANCISCO, CA 94111

CALIFORNIA ENERGY COMMISSION
E.V. (AL) GARCIA
 agarcia@energy.state.ca.us

WOMEN'S ENERGY MATTERS
BARBARA GEORGE
 wem@igc.org

NATIONAL ASSOC. OF ENERGY SVC. COMPANIES
DONALD GILLIGAN
 donaldgilligan@comcast.net

CALIFORNIA ATTORNEY GENERAL'S OFFICE
SANDRA GOLDBERG
 sandra.goldberg@doj.ca.gov

SUSTAINABLE SPACES, INC.
MATT GOLDEN
 matt@sustainablespaces.com

THE UTILITY REFORM NETWORK
HAYLEY GOODSON
 hayley@turn.org

CALIF PUBLIC UTILITIES COMMISSION
David M. Gamson
 dmg@cpuc.ca.gov

PERKINS, MANN & EVERETT, A.P.C.
JERRY H. HANN
 jmann@pmelaw.com

ALLIANCE TO SAVE ENERGY
MERRILEE HARRIGAN
 mharrigan@ase.org

SAN DIEGO GAS & ELECTRIC COMPANY
KIM F. HASSAN
 KHassan@SempraUtilities.com

ELLISON, SCHNEIDER & HARRIS, LLP
LYNN HAUG
 lmh@eslawfirm.com

THE UTILITY REFORM NETWORK
MARCEL HAWIGER
 marcel@turn.org

HELLER MANUS ARCHITECTS
JEFFREY HELLER
 JeffreyH@hellermanus.com

CITY AND COUNTY OF SAN FRANCISCO
DENNIS J. HERRERA
 CITY HALL, ROOM 234
 SAN FRANCISCO, CA 94102

ACCES
JAMES HODGES
 hodgesjl@surewest.net

REDEFINING PROGRESS
J. ANDREW HOERNER
 hoerner@redefiningprogress.org

CALIF PUBLIC UTILITIES COMMISSION
Mikhail Haramati
 mkh@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Katherine Hardy
 keh@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Edward Howard
 trh@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Judith Ikle
 jci@cpuc.ca.gov

SACRAMENTO MUNICIPAL UTILITY DISTRICT
LOURDES JIMENEZ-PRICE
 ljimene@smud.org

BILL JULIAN
 billjulian@sbcglobal.net

THE GREENLINING INSTITUTE
SAMUEL KANG
 samuelk@greenlining.org

THE GREENLINING INSTITUTE
SAMUEL S. KANG
 samuelk@greenlining.org

DISABILITY RIGHTS ADVOCATES
 MELISSA W. KASNITZ
 pucservice@dralegal.org

UTILITY COST MANAGEMENT, LLC
 PAUL KERKORIAN
 pk@utilitycostmanagement.com

DISABILITY RIGHTS ADVOCATES
 MARY - LEE KIMBER
 pucservice@dralegal.org

AIR CONDITIONING CONTRACTORS
 OF AMERICA
 W. RUSSELL KING
 russ.king@acca.org

CAL. BLDG. PERFORMANCE
 CONTRATORS ASSN.
 ROBERT L. KNIGHT
 rknight@bki.com

GLOBAL ENERGY PARTNERS, LLC
 JOHN KOTOWSKI
 jak@gepllc.com

CALIF PUBLIC UTILITIES COMMISSION
 Kimberly Kim
 kk2@cpuc.ca.gov

ASSOCIATION OF BAY AREA
 GOVERNMENTS
 GERALD LAHR
 jerry@abag.ca.gov

ALPINE NATURAL GAS OPERATING
 COMPANY
 MICHAEL LAMOND
 mike@alpinenaturalgas.com

SUNDOWNER INSULATION, INC.
 TIMOTHY J. LAWLER
 sundnr2@sbcglobal.net

SOUTHWEST GAS CORPORATION
 KEITH LAYTON
 keith.layton@swgas.com

DAVIS ENERGY GROUP
 ERIC LEE
 elee@davisenergy.com

CTG ENERGETICS, INC.
 MALCOLM LEWIS
 mlewis@ctg-net.com

DOUGLASS & LIDDELL
 DONALD C. LIDDELL
 liddell@energyattorney.com

JODY LONDON CONSULTING
 JODY LONDON
 jody_london_consulting@earthlink.net

CALIF PUBLIC UTILITIES COMMISSION
 Peter Lai
 ppl@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
 Jean A. Lamming
 jl2@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
 Diana L. Lee
 dil@cpuc.ca.gov

THE METROPOLITAN WATER
 DISTRICT OF SOUTH
 DIANA MAHMUD
 dmahmud@mwdh2o.com

PERKINS, MANN & EVERETT
 JERRY H. MANN
 jmann@pmelaw.com

JBS ENERGY
 BILL MARCUS
 bill@jbsenergy.com

2030, INC./ARCHITECTURE 2030
 EDWARD MAZRIA
 info@architecture2030.org

CALIFORNIA CENTER FOR
 SUSTAINABLE ENERGY
 ANDREW MCALLISTER
 andrew.mcallister@energycenter.org

SUTHERLAND ASBILL & BRENNAN
 LLP
 KEITH R. MCCREA
 keith.mccrea@sutherland.com

DON MEEK
 10949 SW 4TH AVENUE
 PORTLAND, OR 97219

CALIFORNIA FARM BUREAU
 FEDERATION
 KAREN NORENE MILLS
 kmills@cfbf.com

PACIFICORP
 MICHELLE R. MISHOE
 michelle.mishoe@pacificorp.com

ENERGY ECONOMICS INC
 CYNTHIA K. MITCHELL
 ckmitchell1@sbcglobal.net

UC DAVIS WESTERN COOLING
 EFFICENCY CTR
 MARK P. MODERA
 mpmodera@ucdavis.edu

SOUTHERN CALIFORNIA EDISON
 MICHAEL MONTOYA
 montoym1@sce.com

NEWPORT VENTURES
 MIKE MOORE
 mmoore@newportpartnersllc.com

GOLDEN STATE WATER/BEAR
 VALLEY ELECTRIC
 RONALD MOORE
 rkmoore@gswater.com

WESTERN MANUFACTURED HOUSING
 COMM. SVCS.
 IRENE K. MOOSEN
 irene@igc.org

CITY & COUNTY OF SAN FRANCISCO
 STEPHEN A. S. MORRISON
 CITY HALL, SUITE 234
 1 DR CARLTON B. GOODLET PLACE
 SAN FRANCISCO, CA 94102-4682

LAW OFFICES OF SARA STECK
 MYERS
 SARA STECK MYERS
 ssmyers@att.net

ENVIRONMENTAL DESIGN/BUILD
 GEORGE J. NESBITT
 george@houseiasystem.com

CALIFORNIA CENTER FOR
 SUSTAINABLE ENERGY
 SEPHRA A. NINOW
 sephra.ninow@energycenter.org

SOUTHERN CALIFORNIA FORUM
 ARLEEN NOVOTNEY
 social.forum@yahoo.com

PACIFIC GAS AND ELECTRIC
 COMPANY
 CHONDA J. NWAMU
 CJN3@pge.com

CALIF PUBLIC UTILITIES COMMISSION
 David Ng
 dhn@cpuc.ca.gov

DAVIS WRIGHT TREMAINE LLP
 EDWARD W. O'NEILL
 edwardoneill@dwt.com

SOUTHWEST GAS CORPORATION
 VALERIE J. ONTIVEROZ
 valerie.ontiveroz@swgas.com

CALIF PUBLIC UTILITIES COMMISSION
 Ayat E. Osman
 aeo@cpuc.ca.gov

QUEST
 EILEEN PARKER
 2001 ADDISON STREET, STE. 300
 BERKELEY, CA 94704

COMMUNITY ACTION AGENCY OF
 SAN MATEO
 WILLIAM F. PARKER
 wparker@baprc.com

SACRAMENTO MUNICIPAL UTILITY
 DIST.
 JIM PARKS
 jparks@smud.org

SOUTHERN CALIFORNIA GAS
 COMPANY
 STEVEN D. PATRICK
 SDPatrick@SempraUtilities.com

RANCHO VALLEY BUILDERS, INC.
 BRUCE PATTON
 bpatton_rancho@sbcglobal.net

SEMPRA ENERGY
 CARLOS F. PENA
 CFPena@SempraUtilities.com

COMMUNITY RESOURCE PROJECT,
 INC.
 LOUISE A. PEREZ
 lperez@cresource.org

CALIFORNIA CENTER FOR
 SUSTAINABLE ENERGY
 JENNIFER PORTER
 jennifer.porter@energycenter.org

PROCTOR ENGINEERING GROUP
 JOHN PROCTOR
 john@proctoreng.com

CALIF PUBLIC UTILITIES COMMISSION
 Lisa Paulo
 lp1@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
 Anne W. Premo
 awp@cpuc.ca.gov

COMMUNITY ACTION AGENCY OF
 SAN MATEO
 GREGORY REDICAN
 gredican@caasm.org

CALIFORNIA ENERGY COMMISSION
 CYNTHIA ROGERS
 crogers@energy.state.ca.us

MARIN ENERGY MANAGEMENT TEAM
 TIM ROSENFELD
 tim@marinemt.org

RCS, INC.
 JAMES ROSS
 jimross@r-c-s-inc.com

SMALL BUSINESS CALIFORNIA
 HANK RYAN
 hankryan2003@yahoo.com

CALIF PUBLIC UTILITIES COMMISSION
 Sazedur Rahman
 snr@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
 Rashid A. Rashid
 rhd@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
 Thomas Roberts
 tcr@cpuc.ca.gov

CALIFORNIA ENERGY COMMISSION
 IRENE SALAZAR
 isalazar@energy.state.ca.us

SOUTHERN CALIFORNIA EDISON
COMPANY
STACIE SCHAFFER
stacie.schaffer@sce.com

PETER SCHWARTZ & ASSOCIATES,
LLC
PETER M. SCHWARTZ
pmschwartz@sbcglobal.net

SCHWEITZER AND ASSOCIATES, INC.
JUDI G. SCHWEITZER
judi.schweitzer@post.harvard.edu

CHRIS SCRUTON
cscruton@energy.state.ca.us

CALIFORNIA ENERGY COMMISSION
MARGARET SHERIDAN
msherida@energy.state.ca.us

CLEAREDGE POWER CORPORATION
JON W. SLANGERUP
js@clearedgepower.com

CITY AND COUNTY OF SAN
FRANCISCO
JEANNE M. SOLE
jeanne.sole@sfgov.org

MARAVILLA FOUNDATION
ALEX SOTOMAYOR
alexst@aol.com

GOODIN MACBRIDE SQUERI DAY &
LAMPREYLLP
JAMES D. SQUERI
jsqueri@goodinmacbride.com

CALIFORNIA CENTER FOR
SUSTAINABLE ENERGY
IRENE STILLINGS
irene.stillings@energycenter.org

BEAR VALLEY ELECTRIC SERVICE
KEITH SWITZER
kswitzer@gswater.com

CALIF PUBLIC UTILITIES COMMISSION
Don Schultz
dks@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Yuliya Shmidt
ys2@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Joyce Steingass
jws@cpuc.ca.gov

HELLER MANUS ARCHITECTS
REMI TAN
RemiT@hellermanus.com

SILICON VALLEY LEADERSHIP
GROUP
FRANK TENG
224 AIRPORT PARKWAY, SUITE 620
SAN JOSE, CA 95110

SOCALGAS AND SDG&E
MICHAEL R. THORP
MThorp@SempraUtilities.com

ICE ENERGY, INC.
GREG TROPSA
gtropsa@ice-energy.com

CALIF PUBLIC UTILITIES COMMISSION
George S. Tagnipes
jst@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Zenaida G. Tapawan-Conway
ztc@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Matthew Tisdale
mwt@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Ava N. Tran
atr@cpuc.ca.gov

TELACU
RICHARD VILLASENOR
richvilla4@hotmail.com

CALIF PUBLIC UTILITIES COMMISSION
Christopher R Villarreal
crv@cpuc.ca.gov

MODESTO IRRIGATION DISTRICT
JOY A. WARREN
joyw@mid.org

AGLET CONSUMER ALLIANCE
JAMES WEIL
jweil@aglet.org

CITY OF OAKLAND
SCOTT WENTWORTH
swentworth@oaklandnet.com

ELLISON SCHNEIDER & HARRIS L.L.P.
GREGGORY L. WHEATLAND
glw@eslawfirm.com

ROBERT C. WILKINSON
wilkinson@es.ucsb.edu

PACIFIC GAS AND ELECTRIC
COMPANY
SHIRLEY A. WOO
saw0@pge.com

PACIFIC ENERGY POLICY CENTER
DON WOOD SR.
dwood8@cox.net

SOUTH COAST AIR QUALITY
MANAGEMENT DIST
PAUL WUEBBEN
pwuebben@aqmd.gov

BRAUN BLAISING MCLAUGHLIN, P.C.
JUSTIN C. WYNNE
wynne@braunlegal.com

CALIF PUBLIC UTILITIES COMMISSION
Natalie Walsh
nfw@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Karen Watts-Zagha
kwz@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Pamela Wellner
pw1@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Michael Wheeler
mmw@cpuc.ca.gov

CALIF PUBLIC UTILITIES COMMISSION
Sean Wilson
smw@cpuc.ca.gov

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

ATTACHMENT B
Advice No. 4111

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 46068-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 2	Revised 42340-G**
Revised 46069-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 4	Revised 42342-G*
Revised 46070-G	Schedule No. G-AC, CORE AIR CONDITIONING SERVICE, FOR COMMERCIAL AND INDUSTRIAL, Sheet 7	Revised 43438-G
Revised 46071-G	Schedule No. GT-AC, CORE TRANSPORTATION-ONLY AIR CONDITIONING, SERVICE FOR COMMERCIAL AND INDUSTRIAL, Sheet 5	Revised 43439-G
Revised 46072-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY (CARE) PROGRAM FOR QUALIFIED , AGRICULTURAL EMPLOYEE HOUSING (Form 6632-C, 06/10)	Revised 44921-G
Revised 46073-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM FOR QUALIFIED NONPROFIT, GROUP LIVING FACILITIES (Form 6571-C)	Revised 44922-G
Revised 46074-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - GENERAL PURPOSE, DIRECT MAIL (Form No. 6491-DM, 06/10)	Revised 44923-G
Revised 46075-G	SAMPLE FORMS: APPLICATIONS, Self- Certification CARE Application, Individually Metered Residential (Form No. 6491-C, 06/10)	Revised 44924-G
Revised 46076-G	SAMPLE FORMS: APPLICATIONS, Self- Recertification CARE Application, Individually Metered Residential (Form No. 6674-C, 06/10)	Revised 44925-G
Revised 46077-G	SAMPLE FORMS: APPLICATIONS, Capitation Program CARE Application, (Form No. 6491-2C, 06/10)	Revised 44926-G
Revised 46078-G	SAMPLE FORMS: APPLICATIONS, Post- Enrollment Verification CARE Application, Individually Metered Residential (Form No. 6675- C, 06/10)	Revised 44927-G

ATTACHMENT B
Advice No. 4111

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 46079-G	SAMPLE FORMS: APPLICATIONS, Self-Certification CARE Application, Submetered Residential (Form No. 6677-C, 06/10)	Revised 44928-G
Revised 46080-G	SAMPLE FORMS: APPLICATIONS, Self-Recertification CARE Application, Submetered Residential (Form No. 6678-C, 06/10)	Revised 44929-G
Revised 46081-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - BILL INSERT, (Form No. 6491-BI, 06/10)	Revised 44930-G
Revised 46082-G	TABLE OF CONTENTS	Revised 46054-G
Revised 46083-G	TABLE OF CONTENTS	Revised 44931-G
Revised 46084-G	TABLE OF CONTENTS	Revised 46056-G

Schedule No. G-CARE
CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM

Sheet 2

(Continued)

SPECIAL CONDITIONS (Continued)

ALL CUSTOMERS (Continued)

4. Eligibility: A customer can qualify for the CARE discount by meeting either of the two eligibility requirements shown below:

- a. Income Eligibility: An income-qualified customer, submetered tenant, or facility resident has total annual gross household income from all sources that is no more than shown in the table below for the number of persons in the household. The combined income of all persons from all sources, both taxable and non-taxable, shall be no more than:

<u>Number of Persons In Household</u>	<u>Total Annual Household Income</u>
1 or 2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600

For households with more than six persons, add \$7,600 annually for each additional person living in the household. The above income levels are subject to change annually by the Commission.

- b. Categorical Eligibility: If the applicant or any person in the household receives benefits from any of the following programs: Medicaid; Medi-Cal; Healthy Families A&B; Women, Infant & Children (WIC); TANF; Tribal TANF; Head Start income Eligible - Tribal Only; Bureau of Indian Affairs General Assistance; Food Stamps (SNAP); National School Lunch Program (NSLP); Low Income Home Energy Assistance Program (LIHEAP); and Supplemental Security Income (SSI).

The applicant for the CARE discount must be the Utility's customer of record or a submetered tenant of a Utility customer.

No customer, submetered tenant, or facility resident claimed on another person's income tax return shall be eligible for this rate.

5. Verification: Information provided by the customer to the Utility is subject to verification as authorized by the Commission. Refusal or failure to provide documentation of eligibility acceptable to the Utility, upon request, shall result in the denial or termination of the CARE discount.

6. Backbilling: Customers may be backbilled under the applicable rate schedule for periods of ineligibility and/or if the direct benefits to a facility's residents claimed by the customer cannot be supported.

(Continued)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
 DECISION NO.

2H7

ISSUED BY

Lee Schavrien
 Senior Vice President
 Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
 EFFECTIVE Jun 1, 2010
 RESOLUTION NO. E-3524

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Schedule No. G-CARE

Sheet 4

CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM

(Continued)

SPECIAL CONDITIONS (Continued)

NON-PROFIT GROUP LIVING FACILITY CUSTOMERS (Continued)

13. Eligibility Criteria (Continued)

- b. The facility must provide a copy of its IRS Nonprofit Tax ID Form No. 501(c)(3) and state business license, conditional use permit or other proof satisfactory to the Utility. Separately metered satellite facilities in the name of the licensed facility, where 70% of the energy supplied is for residential purposes, are also eligible.
 - c. With the exception of homeless shelters, all facilities must certify that 100% of the residents of the facility individually meet the CARE eligibility standard for a single-person household. A caregiver who lives in the facility is not a resident for purposes of determining eligibility. A single-person household is eligible for the CARE discount if total annual gross income does not exceed \$31,300.
 - d. With the exception of homeless shelters, all facilities must certify that they provide a "special needs" social service, such as meals, job development training, or rehabilitation programs, in addition to lodging for residents who qualify for the CARE discount.
 - e. Homeless shelters must certify that they provide at least six beds per day or night for a minimum of 180 days each year for persons who have no alternative residence.
 - f. The facility must certify that at least 70% of the energy supplied to the facility's premises is used for residential purposes.
 - g. Government-owned facilities are not considered qualified non-profit group living facilities, unless they are a qualified non-profit homeless shelter as defined above.
14. Certification of Benefits: At the time of annual renewal of eligibility, each facility is required to certify that monies saved through the CARE discount have benefited the residents of the facility who qualify for the CARE discount. Certification shall be made under penalty of perjury and include a quantification of funds saved annually due to the CARE discount, and identify how those funds have been spent for the benefit of the qualifying residents.

(Continued)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524

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Schedule No. G-AC

Sheet 7

CORE AIR CONDITIONING SERVICE
FOR COMMERCIAL AND INDUSTRIAL

(Continued)

SPECIAL CONDITIONS (Continued)

CARE (Continued)

15. (Continued)

Income Eligibility Requirements for Residents: The total annual household income from all sources (taxable and non-taxable) shall not be more than \$31,300 for each resident of the facility, and the resident shall not be claimed on another person's income tax return.

The owner or authorized representative of the facility shall notify the Utility within 30 days following any change that may impact the facility's eligibility for the discount.

Self-Certification and Self-Recertification Requirements: Non-profit group living facilities must provide proof of the appropriate state license to care for residents who, either temporarily or permanently, cannot function normally outside of the group-home environment and certification from the appropriate state agency showing what services, besides lodging, are provided, or any other proof satisfactory to the Utility. Primary facilities must meet the licensing and certification requirements, but not their separately metered affiliated facilities.

Homeless shelters must provide verification that at least six (6) beds each day or night are provided a minimum of 180 days each year for persons who have no alternate residence, and must provide proof of a valid municipal or county conditional-use permit or any other proof satisfactory to the Utility. Non-profit group living facilities are not required to be licensed or certified.

Self-Recertification Requirements: Facilities will be required to recertify on an annual basis. At the time of each annual certification, the Utility shall require the facility, including homeless shelters, to certify how it intends to pass on the rate discount.

Random Post-Enrollment Verification: The self-certification and self-recertification applications for CARE benefits, and certification of the flow-through of the rate discount, shall be made under penalty of perjury under the laws of the State of California by the same individual who is responsible for the annual renewal of the facility's license from the appropriate state agency, when applicable. The accuracy of the self-certification or self-recertification applications may be subject to random post-enrollment verification by the Utility.

(Continued)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524

Schedule No. GT-AC

Sheet 5

CORE TRANSPORTATION-ONLY AIR CONDITIONING
SERVICE FOR COMMERCIAL AND INDUSTRIAL

(Continued)

SPECIAL CONDITIONS (Continued)

CARE

18. Eligibility Requirements: The CARE discount shall apply to non-profit group living facilities and non-licensed, separately metered affiliated facilities, such as homeless shelters, women's shelter, transitional housing (e.g., for drug rehabilitation, halfway house, etc.), short- or long-term care facility (hospice, nursing home, senior's or children's home), a group home for physically or mentally disabled persons, or non-profit residential facility whose construction was government-subsidized and meets all other applicable criteria. Student housing/dorms, military barracks, fraternities/sororities, government-owned, and privately owned "for profit" government-subsidized housing are excluded. The exclusion of government-owned and government-subsidized housing does not apply to homeless shelters.

The discount shall apply to non-licensed, separately metered affiliates of qualifying non-profit group facilities so long as the customer of record is the qualifying non-profit facility.

Each resident of the facility or the non-licensed, separately metered facility (100%) must meet the CARE income eligibility standards for a single-person household to qualify for the G-ACL rate. At least 70% of the energy consumed on the CARE rate must be used for residential purposes.

SoCalGas shall require the facility to provide a copy of its IRS Non-Profit Tax ID Form 501(c)(3), and state business license, conditional use permit or any other proof satisfactory to SoCalGas. Facilities that have been qualified by SoCalGas under self-certification or self-recertification and are receiving the rate discount may be subject to random post-enrollment verification by SoCalGas.

An authorized representative of the facility shall sign Form No. 6571 certifying that any savings derived from the discount shall be used for the direct benefit of the residents. Such direct benefit may be in the form of improved quality of care or improved food service.

Customers who are found to be ineligible or fail to timely notify SoCalGas when they no longer qualify for the rate discount may be subject to corrective rebilling under the appropriate rate schedule.

Upon completion of Form No. 6571 and acceptance, eligible facilities or their affiliates shall receive the discount commencing with the next regularly scheduled bill.

Income Eligibility Requirements for Residents: The total annual household income from all sources (taxable and non-taxable) shall not be more than \$31,300 for each resident of the facility, and the resident shall not be claimed on another person's income tax return.

(Continued)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
SUBMITTED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY (CARE) PROGRAM FOR QUALIFIED
AGRICULTURAL EMPLOYEE HOUSING (Form 6632-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H7

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



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 Program (NSLP), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2010 to May 31, 2011)</i>	
Number of Persons in Household	Total Annual Income* <small>*current household income from all sources before deductions</small>
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Each additional household member, add	\$7,600

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

ELIGIBLE FACILITIES

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

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

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

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

APPLICANTS RESPONSIBILITIES

The applicant is required to:

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



Application for 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)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H5

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524

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.



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 <input type="checkbox"/>	No <input type="checkbox"/>
Does nonprofit corporation operation facility have a tax-exempt status under Internal Revenue Section 501(c)(3)?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the facility government-owned or operated?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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	<input type="checkbox"/>	Satellite Facility? Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/>	No <input type="checkbox"/>

(Continued on Back)



Please complete the following information for all qualified satellite facilities:

Glad to be of service.®

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



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 6571B 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:

OR

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

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 Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)	Number Of Persons	Total Yearly Individual Resident's Income In Facility Cannot Be More Than*
	1-2	\$31,300
	3	\$36,800
	4	\$44,400
	5	\$52,000
	For Each Additional Person Add: \$7,600	

* Effective date: June 1, 2010 to May 31, 2011

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, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H6

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



A Sempra Energy utility®

CARE

20% DISCOUNT

Dear Customer,

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

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

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 Program (NSLP)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)



2 MAXIMUM HOUSEHOLD INCOME:

(effective June 1, 2010 to May 31, 2011)

Number of Persons in Household	Total Annual Income*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600

For each additional household member, add \$7,600

* 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
CARE Program Sr. Market Advisor



A Semptra Energy utility®

CARE APPLICATION

FOR A 20% DISCOUNT

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

NAME:

ADDRESS:

CITY/ZIP:

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)

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

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, enter the dollar amount here: \$, .00 per year

Please mark your sources of income:

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



A Semptra Energy utility®

CARE

20% DE DESCUENTO

Estimado Cliente:

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

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

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:

<p>1 PROGRAMAS DE ASISTENCIA PÚBLICA: Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:</p> <ul style="list-style-type: none"> Medi-Cal/Medicaid Healthy Families Categories 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 National School Lunch Program (NSLP) Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP) Ingreso Suplementario del Seguro Social (SSI) 	← 0 →	<p>2 INGRESO MÁXIMO EN EL HOGAR: (en vigor del 1 de junio de 2010 al 31 de mayo de 2011)</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Número de personas en el hogar</th> <th>Ingreso total anual*</th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">1-2</td> <td style="text-align: right;">\$31,300</td> </tr> <tr> <td style="text-align: center;">3</td> <td style="text-align: right;">\$36,800</td> </tr> <tr> <td style="text-align: center;">4</td> <td style="text-align: right;">\$44,400</td> </tr> <tr> <td style="text-align: center;">5</td> <td style="text-align: right;">\$52,000</td> </tr> <tr> <td style="text-align: center;">6</td> <td style="text-align: right;">\$59,600</td> </tr> <tr> <td colspan="2" style="text-align: center;">Por cada miembro adicional en el hogar, añada \$7,600</td> </tr> </tbody> </table> <p><small>* Incluye los ingresos actuales del hogar de todas las fuentes de ingreso antes de deducciones.</small></p>	Número de personas en el hogar	Ingreso total anual*	1-2	\$31,300	3	\$36,800	4	\$44,400	5	\$52,000	6	\$59,600	Por cada miembro adicional en el hogar, añada \$7,600	
Número de personas en el hogar	Ingreso total anual*															
1-2	\$31,300															
3	\$36,800															
4	\$44,400															
5	\$52,000															
6	\$59,600															
Por cada miembro adicional en el hogar, añada \$7,600																

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
Gerente del programa CARE



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:

TELÉFONO 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)

- | | |
|--|--|
| <ul style="list-style-type: none"> <input type="radio"/> Medi-Cal / Medicaid: menor de 65 años <input type="radio"/> Medi-Cal / Medicaid: 65 años o más <input type="radio"/> Healthy Families Categories A & B <input type="radio"/> Programa para Mujeres, Infantes y Niños (WIC) <input type="radio"/> Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal <input type="radio"/> Cupones para alimentos / SNAP | <ul style="list-style-type: none"> <input type="radio"/> Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP) <input type="radio"/> Ingreso Suplementario del Seguro Social (SSI) <input type="radio"/> National School Lunch Program (NSLP) <input type="radio"/> Agencia de Asuntos Indios, Asistencia General (BIA GA) <input type="radio"/> 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, escriba la suma anual: \$, .00

Por favor marque sus fuentes de ingreso:

- | | | |
|--|--|---|
| <ul style="list-style-type: none"> <input type="radio"/> Seguro Social <input type="radio"/> SSP o SSDI <input type="radio"/> Pensiones <input type="radio"/> Intereses o dividendos de cuentas de ahorro, acciones, bonos, o cuentas para el retiro | <ul style="list-style-type: none"> <input type="radio"/> Salarios y/o ingresos de autoempleo <input type="radio"/> Beneficios de desempleo <input type="radio"/> Pagos de pólizas de seguro o convenios judiciales <input type="radio"/> Pagos por incapacidad o indemnización para los trabajadores | <ul style="list-style-type: none"> <input type="radio"/> Pension conyugal o alimenticia <input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida <input type="radio"/> Ingresos por alquiler o regalías <input type="radio"/> 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

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Individually Metered Residential (Form No. 6491-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



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 CompanySM.

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 Program (NSLP), Low Income Home Energy Assistance Program, Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective June 1, 2010 to May 31, 2011)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Each additional household member, add	\$7,600

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, 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.

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)



Sempra Energy utility

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 (06/10)

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: _____

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) ▼

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

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, enter amount here: \$ _____,_____.00 per year

Please mark your sources of income: ▼

<input type="radio"/> Social Security	<input type="radio"/> Wages and/or Profit from Self Employment	<input type="radio"/> Spousal or Child Support
<input type="radio"/> SSP or SSDI	<input type="radio"/> Unemployment Benefits	<input type="radio"/> Scholarships, grants, or other aid used for living expenses
<input type="radio"/> Pensions	<input type="radio"/> Insurance or Legal Settlements	<input type="radio"/> Rental or Royalty Income
<input type="radio"/> Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts	<input type="radio"/> Disability or Workers Compensation Payments	<input type="radio"/> 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: _____ Date: ____ / ____ / ____

DATE : 06 / 01 / 2010



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 CompanySM.

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 Healthy Families 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) National School Lunch Program (NSLP) 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 2010 al 31 de mayo de 2011) *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Por cada miembro adicional en el hogar, añada	\$7,600

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 (06/10)

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: () -

E-mail:

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) ▼

<input type="radio"/> Medi-Cal / Medicaid: menor de 65 años	<input type="radio"/> Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
<input type="radio"/> Medi-Cal / Medicaid: 65 años o más	<input type="radio"/> Ingreso Suplementario del Seguro Social (SSI)
<input type="radio"/> Healthy Families Categorías A & B	<input type="radio"/> National School Lunch Program (NSLP)
<input type="radio"/> Programa para Mujeres, Infantes, y Niños (WIC)	<input type="radio"/> Agencia de Asuntos Indios, Asistencia General (BIA GA)
<input type="radio"/> Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal
<input type="radio"/> Cupones para alimentos / SNAP	

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, escriba el monto aquí : \$, .00 al año

Por favor marque sus fuentes de ingreso: ▼

<input type="radio"/> Seguro Social	<input type="radio"/> Salarios y/o ingresos de autoempleo	<input type="radio"/> Pensión conyugal o alimenticia
<input type="radio"/> SSP o SSDI	<input type="radio"/> Beneficios de desempleo	<input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
<input type="radio"/> Pensiones	<input type="radio"/> Pagos de pólizas de seguro o convenios judiciales	<input type="radio"/> Ingresos por alquiler o regalías
<input type="radio"/> Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro	<input type="radio"/> Pagos por incapacidad o Indemnización para los trabajadores	<input type="radio"/> 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:

Fecha : / /

DATE: 06/01/2010



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 CompanySM 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:	家庭收入最高限額*:	
<p>如果您或您的家人從下列任一計劃中受益:</p> <p>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 Program (NSLP, 全國學童午餐計劃)、Low Income Home Energy Assistance Program (LIHEAP, 低收入家庭能源協助計劃)、Supplemental Security Income (SSI, 社會安全補助金)</p>	<p>(有效期 2010 年 6 月 1 日至 2011 年 5 月 31 日) *包括所有來源的家庭現有稅前收入</p>	
或	家庭成員人數	年收入總額
	1-2	\$31,300
	3	\$36,800
	4	\$44,400
	5	\$52,000
	6	\$59,600
	每多一位家庭成員, 增加	\$7,600

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、緊急帳單協助和增強禦寒性能服務。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

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



SEMPRA ENERGY utility

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

正確塗圈方法: ●

Form 6491-C CH (06/10)

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）▼

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

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 (稅前收入, 包括所有家庭成員), 把適當項目前的圓圈塗黑: ▼

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

如果多於 \$59,600, 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: ▼

- | | | |
|--|---------------------------------|--|
| <input type="radio"/> 社會安全福利金 Social Security | <input type="radio"/> 工資或薪金 | <input type="radio"/> 配偶或子女支付的贍養費 |
| <input type="radio"/> 社會安全輔助金 SSP, SSDI | <input type="radio"/> 失業救濟金 | <input type="radio"/> 獎學金, 助學金, 或其它用於支付生活費用的助學津貼 |
| <input type="radio"/> 退休金 | <input type="radio"/> 保險或法律賠償 | <input type="radio"/> 租金或權利金收入 |
| <input type="radio"/> 從以下項目獲取的利息或紅利: 儲蓄帳戶, 股票, 債券, 或退休帳戶 | <input type="radio"/> 殘疾津貼或勞工補償 | <input type="radio"/> 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:

日期: / /

DATE: 06/01/2010



20% CARE 할인 신청서

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 CompanySM에서 승인하면 할인이 적용될 것입니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:
<p>귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:</p> <p>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 무료점심 프로그램 (National School Lunch Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)</p>

또는

최대 가구 소득*: (2010. 6. 1 부터 2011. 5. 31 까지 유효) *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
추가되는 식구 1 인당 추가액	\$7,600

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 찬장 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.

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.

Medical Baseline (의료 저율요금) – 특정한 의학적 상태에 처한 고객들에게 저렴한 요금으로 추가 할당량의 가스를 제공합니다. 자세한 내용은 1-800-427-0471 번으로 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 광둥어: 1-800-427-1420 월남어: 1-800-427-0478
- 청각 장애자(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)



Sempra Energy utility

CARE 20% 요금 할인 신청서

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

Form 6491-C KO (06/10)

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

아니오 (아니오인 경우 다음 질문사항을 계속하십시오)▼

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

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

\$59,600 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간\$ _____,_____.00

귀하의 소득원에 표시하십시오: ▼

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

DATE : 06/01/2010



A Sempra Energy utility

Form 6491-C VI (06/10)

ĐƠN XIN GIẢM GIÁ CARE 20%

ĐƠN XIN HƯỜNG 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 CompanySM 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,
 Chương trình 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),
 Bureau of Indian Affairs General Assistance,
 Food Stamps (SNAP),
 Chương trình Toàn quốc ăn Trưa Trường (NSLP),
 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, 2010 đến 31 tháng Năm, 2011)
 *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	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Mỗi người Thêm vào trong Gia Đình, được cộng thêm	\$7,600

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: ●

Form 6491-C VI (06/10)

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 / Medicaid: Dưới 65 tuổi
- Medi-Cal / Medicaid: 65 tuổi hoặc hơn
- Gia Đình Khỏe Mạnh Loại A & B
- Chương Trình Phụ Nữ Sơ Sinh và Trẻ Em (WIC)
- Trợ Giúp Tạm Thời Cho Gia Đình có Nhu Cầu (TANF) hoặc TANF Bản Địa
- Phiếu Thực Phẩm/SNAP
- Trợ Giúp Năng Lượng Tại Gia Cho Người Lợi Tức Thấp (LIHEAP)
- Trợ Cấp An Sinh (SSI)
- Chương trình Toàn quốc ăn Trưa Trường (NSLP)
- Bureau of Indian Affairs General Assistance
- Đủ điều kiện lợi tức cho Head Start (Bản Địa mà thôi)

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 - \$31,300
- \$31,301 - \$36,800
- \$36,801 - \$44,400
- \$44,401 - \$52,000
- \$52,001 - \$59,600
- Nếu nhiều hơn \$59,600, 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 Lãi hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí
- Lương và/hoặc Lợi tức Việc 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 Phôi 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 chứng 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: / /

DATE : 06/01/2010

يوفر برنامج الأسعار البديلة للطاقة بولاية كاليفورنيا (California Alternate Rates for Energy, CARE) من شركة The Gas CompanySM تخفيضاً مقداره 20% على فاتورة الغاز الشهرية للعائلات المؤهلة. كما سيتلقى أولئك المؤهلون والذين تمت الموافقة عليهم خلال 90 يوماً من بدء خدمة غاز جديدة تخفيضاً قدره 15 دولاراً من تكلفة تأسيس الخدمة. سيتم البدء في تطبيق التخفيض بعد أن توافق The Gas CompanySM على طلبك الموقع.

يرجى ملء الطلب وإعادةه في الظرف المرفق أو التقدم بطلب على الإنترنت بالعنوان التالي
<http://www.socalgas.com/assistance/care/>

كيف تتأهل للحصول على تخفيض CARE

برامج المساعدة الحكومية:	الحد الأعلى لدخل العائلة*:
إذا كنت أنت أو أي من أفراد أسرتك تتلقون معونات من أي من البرامج التالية:	(ساري المفعول من 1 يونيو 2010 إلى 31 مايو 2011) * دخل العائلة الجاري من جميع المصادر قبل الحسم
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 Program (NSLP), Low Income Home Energy Assistance Program Supplemental Security Income (SSI)	الدخل السنوي الإجمالي
أو	عدد أفراد العائلة
	31300 دولار
	36800 دولار
	44400 دولار
	52000 دولار
	59600 دولار
	7600 دولار
	لكل فرد إضافي في العائلة، أضف

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 يوماً إذا فقدت تأهلك لهذا البرنامج. / قد يُطلب منك إثبات تأهلك للمشاركة في برنامج CARE.

قد تتأهل لبرامج أو خدمات أخرى:

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



A Sempra Energy utility™

طلب تخفيض 20% خاص ببرنامج CARE

يُرجى استخدام حبر غامق والكتابة بخط واضح حتى تتم دراسة الطلب بالشكل الصحيح
الطريقة الصحيحة لتعليم الدوائر: ●

Form 6491-C ARA (06/10)

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

<input type="text"/>	اسم العميل (كما يظهر على الفاتورة)
<input type="text"/>	العنوان (اسم الشارع والمدينة والرمز البريدي)
<input type="text"/>	رقم الحساب
<input type="text"/>	رقم الهاتف
<input type="text"/>	البريد الإلكتروني

1

<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="checkbox"/> 6+	عدد الأفراد البالغين والأطفال في عائلتك
<p>هل تشارك أنت (أو شخص آخر في عائلتك) في أي واحد من البرامج التالية؟</p> <p><input type="radio"/> نعم (إذا أُجبت نعم ضع علامة أمام البرنامج أو البرامج التي تشارك فيها ثم انتقل إلى السؤال 3)</p>	
<input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP) <input type="radio"/> Medi-Cal / Medicaid أقل من 65 سنة <input type="radio"/> Supplemental Security Income (SSI) <input type="radio"/> 65 Medi-Cal / Medicaid سنة أو أكثر <input type="radio"/> National School Lunch Program (NSLP) <input type="radio"/> Healthy Families Categories A & B <input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA) <input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Head Start Income Eligible فقط <input type="radio"/> Temporary Assistance for Needy Families (TANF) or Tribal TANF <input type="radio"/> Food Stamps / SNAP	
<p><input type="radio"/> لا (إذا أُجبت لا، الرجاء الإجابة على الأسئلة التالية)</p> <p>إذا لم تكن مشتركاً في أحد البرامج المدرجة أعلاه، يُرجى ذكر دخل العائلة السنوي (قبل الخصومات بما فيه جميع أفراد العائلة)؟</p> <p><input type="radio"/> 0-31300 دولار <input type="radio"/> 31301-36800 دولار <input type="radio"/> 36801-44400 دولار <input type="radio"/> 44401-52000 دولار <input type="radio"/> 52001-59600 دولار</p> <p><input type="radio"/> إذا زاد الدخل عن 59600 دولار ضع الرقم هنا: \$ <input type="text"/>, <input type="text"/>.00 في السنة</p>	
<input type="radio"/> نفقة زوجية أو نفقة طفل <input type="radio"/> المرتبات والأجور و/أو أرباح من عمل حر <input type="radio"/> Social Security <input type="radio"/> منح أو منح مدرسية أو منح أخرى <input type="radio"/> تعويضات العاطلين عن العمل <input type="radio"/> SSDI أو SSP <input type="radio"/> تُستعمل لنفقات العيش <input type="radio"/> تسويات قانونية أو تأمين <input type="radio"/> معاش <input type="radio"/> إيجار أو علاوات <input type="radio"/> تعويضات عجز (إعاقة) أو تعويضات العاملين <input type="radio"/> فوائد أو أرباح من: <input type="radio"/> نقد أو مصدر دخل آخر <input type="radio"/> حسابات ادخار أو أسهم أو سندات أو حسابات تقاعد	

2

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 طلب مني. كما أوافق على إبلاغ The Gas Company في حال لم أعد مؤهلاً لاستلام التخفيض. إنني أعرف أنه في حال استلامي التخفيض دون أن أكون مؤهلاً، فقد يُطلب مني دفع التخفيضات التي استلمتها. كما أعرف بأن The Gas Company قد تقدم معلوماتي إلى شركات خدمات أو مكاتب أخرى لإدراجي في برامج المساعدة الخاصة بهم.

التوقيع التاريخ

3

Source Code: 9B



20% CARE
ՁԵՂՉԻ ԴԻՍՈՒՄ



The Gas Company-ի California Alternate Rates for Energy (CARE) (Կալիֆորնիայի Այլընտրանքային Գները Էներգիայի համար) որակավորվող ընտանիքներին ծրագիրը ապահովում 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 Գանձման համար: Ձեղչը կկիրառվի, երբ ձեր լրացված և ստորագրված դիմումը վավերացվի The Gas CompanySM-ի կողմից:

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

ԻՆՉՊԵՍ ՈՐԱԿԱՎՈՐՎԵԼ CARE ՁԵՂՉԻ ՀԱՄԱՐ.

ՀԱՍԱՐԱԿԱԿԱՆ ՕՁՆՈՒԹՅԱՆ ԾՐԱԳՐԵՐԸ՝
Եթե դուք կամ ձեր ընտանիքից ուրիշ անդամ մասնակցում եք հետևյալ ծրագրերից որևէ մեկին
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 Program (NSLP), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

ԿԱՍ

ԱՌԱՎԵԼԱԳՈՒՅՆ ԸՆՏԱՆԵԿԱՆ ԵԿԱՄՈՒՏ՝ (ուժի մեջ է հունիսի 1, 2010թ. մինչև մայիսի 31, 2011թ.) *Ներկա ընտանեկան եկամուտը բոլոր աղբյուրներից՝ մինչև կրճատումները	
Ընտանիքի անդամների թիվը	Ընդ. տարեկան եկամուտը
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Ամեն մի լրացուցիչ ընտանիքի անդամի համար ավելացրեք	\$7,600

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 որակավորված չեք: / Ձեզանից կարող է խնդրվել ստուգել CARE-ի Ձեր որակավորումը:

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

DAP - Direct Assistance Program, ցածր եկամտի Էներգիայի արդյունավետության ծրագիր է, որն առաջարկում է անվճար Էներգիա խնայող տնային բարելավումներ, ինչպիսիք են առաստաղի մեկուսացում, դռան եղանակային մերկացում, գաճում և մանր տնային վերանորոգումներ: Լրացուցիչ տեղեկությունների համար խնդրվում է զանգահարել 1-800-331-7593 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 տրամադրում է հաշիվների վճարման օգնություն, վթարների օգնություն և եղանակի հետ կապված ծառայություններ: Չանգահարեք California Department of Community Services and Development 1-866-675-6623 հեռախոսի համարով:

California Lifeline - Ձեղչով հեռախոսային ծառայություն՝ CARE-ի նման եկամտային չափանիշներին որակավորված հաճախորդների համար: Լրացուցիչ տեղեկությունների համար դիմեք ձեր տեղական հեռախոսային ծառայությունների մատակարարողին:

CARE ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐԻ ՀԱՄԱՐ, ՉԱՆԳԱՅԱՐԵՔ THE GAS COMPANY-ԻՆ՝
1-888-427-1345



CARE 20% Գնային Չեղջի Դիմում

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

Form 6491-C ARM (06/10)

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

1

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+

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

- ԱՅՈ** (Եթե այո, ապա նշեք մասնակցության ծրագիր(եր)ը և անցեք հարց 3-ին)▼
 - Medi-Cal / Medicaid: մինչև 65 տարեկան
 - Medi-Cal / Medicaid: 65 տարեկան կամ ավել
 - Healthy Families Categories A & B
 - Women, Infants, and Children Program (WIC)
 - Temporary Assistance for Needy Families (TANF) կամ Tribal TANF
 - Food Stamps / SNAP
 - Low Income Home Energy Assistance Program (LIHEAP)
 - Supplemental Security Income (SSI)
 - National School Lunch Program (NSLP)
 - Bureau of Indian Affairs General Assistance (BIA GA)
 - Head Start Income Eligible - Tribal Only

ՈՉ (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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Եթե \$59,600-ից ավել է, ապա լրացրեք այստեղ. \$, .00 տարեկան

Խնդրվում է նշել Ձեր եկամտի աղբյուրները. ▼

- Social Security
- SSP կամ SSDI
- Կենսաթոշակ
- Տոկոս կամ շահաբաժին՝ ինսայդական հաշիվներից, բաժնետոմսերից, արժեթղթերից կամ թոշակի հաշվից
- Աշխատավարձ և/կամ շահույթ սեփական գործից
- Գործազրկության նպաստ
- Ապահովագրության կամ իրավական լուծում
- Հաշմանդամության կամ Աշխատողի փոխհատուցման վճարումներ
- 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 տրամադրած տեղեկությունները ճշմարիտ են և ճշգրիտ: Ես համաձայն եմ տրամադրել CARE որակավորման 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՝ Ամսաթիվ՝ / /



برنامه «نرخهای جایگزین انرژی شرکت گاز برای کالیفرنیا» (CARE) برای خانواده های واجد شرایط 20% تخفیف در قبض ماهیانه گاز قائل میشود. بعلاوه، آنهایی که واجد شرایط بوده و در ظرف 90 روز از شروع خدمات جدید گاز مورد تایید قرار گیرند 15 دلار تخفیف دیگر در «هزینه راه اندازی خدمت» خواهند گرفت. تخفیف موقعی تعلق میگیرد که تقاضانامه تکمیل و امضاء شده شما توسط شرکت گاز (The Gas CompanySM) تصویب شده باشد.

لطفا این تقاضا نامه را تکمیل کرده و در پاکتی 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

حداکثر درآمد خانوار*:	
(قابل اجرا از 1 ماه ژوئن 2010 تا 31 ماه مه 2011)	
* درآمد کنونی خانوار از تمام منابع درآمد قبل از کسورات	
کل در آمد سالانه	تعداد اعضاء در خانوار
\$31,300	2-1
\$36,800	3
\$44,400	4
\$52,000	5
\$59,600	6
\$7,600	برای هر فرد اضافه در خانوار بیافزایید

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)، مدیکال (Medi-Cal)، «خانواده های تندرست - برنامه الف و ب» (Healthy Families A&B)، «برنامه تغذیه مکمل زنان، نوزادان و کودکان» (WIC)، «کمک موقت به خانواده های نیازمند» (TANF)، واجدین شرایط «برنامه هد استارت» (Head Start) - فقط برای قبیله ها، «کمک عمومی اداره امور سرخپوستان»، «کوپون مواد غذایی» (SNAP)، «برنامه ملی نهار مدارس» (NSLP)، «برنامه کمک هزینه انرژی درخانه اشخاص کم درآمد» (LIHEAP)، «درآمد مکمل تأمین اجتماعی» (SSI)

شرایط مشارکت

قبض گاز باید به نام شما و آدرس باید آدرس اصلی شما باشد. / کسی غیر از همسران شما را به عنوان وابسته در اظهاریه مالیات بر درآمد خویش ذکر نکرده باشد. / هرگاه از شما تقاضا شود، باید تقاضانامه خود را مجدداً تأیید نمایید. / اگر شما دیگر واجد شرایط نباشید باید شرکت گاز (The Gas Company) را ظرف 30 روز مطلع سازید. / ممکن است از شما خواسته شود تا صلاحیت خود را برای CARE اثبات کنید.

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

DAP: «برنامه کمک مستقیم»، برنامه ای برای افراد کم درآمد جهت بهینه سازی مصرف انرژی است که به شما در مرمت منزلتان برای حد اکثر صرفه جویی در انرژی کمک رایگان میدهد، از جمله برای عایق سازی سقف، درزگیری درها، درز بندی و تعمیرات جزئی منزل. جهت کسب اطلاعات بیشتر با این شماره تماس بگیرید: 1-800-331-7593.

Medical Baseline: این برنامه مقادیر دیگری گاز به قیمت نازلتر برای مشتریانی که بیماری های خاصی دارند فراهم میکند. برای کسب اطلاعات بیشتر با این شماره تماس بگیرید: 1-800-427-2200.

LIHEAP: برنامه کمک انرژی برای خانواده های کم درآمد خدمات کمک پرداخت قبض، کمک اضطراری برای پرداخت قبض، عایق بندی در برابر سرما و گرما فراهم میکند. با سازمان خدمات اجتماعی و عمران کالیفرنیا (California Dept. of Community Services and Development) به شماره 1-866-675-6623 تماس بگیرید.

California Lifeline: تخفیف برای گرفتن خط تلفن برای مشتریانی که وضعیت درآمدشان مشابه شرایط CARE است. برای اطلاعات بیشتر با شرکت تلفن محل خود تماس بگیرید.

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



تقاضا نامه 20% تخفیف مراقبت (CARE)

(لطفاً از جوهر تیره استفاده کرده و با حروف جداگانه واضح بنویسید تا از رسیدگی مناسب اطمینان حاصل شود) روش صحیح برای علامت گذاشتن: ●

Form 6491-C FAR (06/10)

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

1

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

نشانی منزل
(خیابان، شهر، کد پستی):

شماره حساب:

شماره تلفن:

نشانی پست الکترونیک یا ایمیل:

2

تعداد کل افراد بزرگسال و
خردسال در خانوار شما:

1 2 3 4 5 6 6+

آیا شما (یا فردی در خانوار شما) برای یکی از برنامه های کمکی زیر ثبت نام کرده اید؟

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

- «برنامه کمک هزینه انرژی برای خانواده های کم درآمد»
- (LIHEAP)
- «درآمد مکمل تأمین اجتماعی» (SSI)
- «برنامه ملی نهار مدارس» (NSLP)
- «کمک عمومی اداره امور سرخپوستان» (BIA GA)
- «واجبین شرایط برنامه هد استارت» (Head Start) – فقط برای قبيله ها
- مدیکل/مدیکید: زیر سن 65
- مدیکل/مدیکید : 65 یا بالاتر
- «خانواده های تندرست - برنامه الف و ب» (Healthy Families A&B)
- «برنامه تغذیه مکمل زنان، نوزادان و کودکان» (WIC)
- «کمک موقت به خانواده های نیازمند» (TANF) یا قبيله ای TANF
- «کوپون مواد غذایی» (SNAP)

خیر (اگر پاسخ منفی است لطفاً به سؤال بعدی مراجعه کنید) ◀

اگر شما در حال حاضر در هیچ یک از برنامه های فوق ثبت نام نکرده اید، در آمد سالانه خانوار شما (پیش از کسورات، شامل تمام اعضاء خانوار) چقدر میباشد؟ ▼

- \$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

اگر سالیانه بیشتر از \$59,600 میباشد مقدار را در اینجا بنویسید: \$, .00

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

- حق بیمه اجتماعی
- SSP (مزایای بیمه بهداشت) یا SSDI (بیمه از کار افتادگی)
- حقوق بازنشستگی
- بهره یا سود سهام: پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی
- دستمزد و/یا سود شغل آزاد
- مزایای بیکاری
- بیمه یا غرامت های حقوقی
- از کار افتادگی یا پرداختی های بیمه کارکنان
- نفقه همسر و فرزند
- بورس تحصیلی، عطیه مالی بلاعوض، یا هر گونه کمک هزینه زندگی
- در آمد از محل اجاره یا حق امتیاز پول نقد یا هر نوع در آمد دیگر

آیا با متن زیر موافقت هستید؟ لطفاً بخوانید و در زیر امضاء کنید.

من اعلام میکنم که اطلاعاتی که در این تقاضانامه ارائه داده ام صحیح و درست است. من موافقت میکنم تا در صورت لزوم مدارکی در اثبات واجد شرایط بودنم برای CARE ارائه کنم. من موافقت میکنم که اگر دیگر واجد شرایط برخورداری از تخفیف نباشم 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 اختیار سایر شرکت های یا کارگزاران خدمات مصرفی بگذارد تا آنها مرا در برنامه های کمکی آنها ثبت نام کنند.

تاریخ: / /

امضاء:

3

Source Code: 9B



A Sempra Energy utility

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 hnuv 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 CompanySM tau pom zoo lawm tso.

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

LI CAS 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 Program (NSLP) (Kev Pab Su Dawb Hauv Teb Chaws Cov 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 TSI PUB TSEV NEEG TAU DHAU*: <i>(pib rau June 1, 2010 txog May 31, 2011)</i> *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	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Txhua Tus Neeg Tauj Ntxiv Ces, Ntxiv	\$7,600

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 hnuv 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 npe nkev tsawg rau tej tus uas muaj tej hom kev mob kev nkeeg. 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 (06/10)

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



1

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

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

Tus Lej Askhauj:

Tus Xov tooj: () -

Tus E-mail:

2

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

Koj (los sis 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
 - Low Income Home Energy Assistance Program (LIHEAP) (Kev Pab Cuam Luv Nqi Hluav Taws Xob)
 - Medi-Cal / Medicaid: 65 lossis Laus Dua
 - Supplemental Security Income (SSI) (Nyiaj Laus, Nyiaj Xiam Oob Khab)
 - Healthy Families Categories A & B
 - National School Lunch Program (NSLP) (Kev Pab Su Dawb Hauv Teb Chaws Cov Tsev Kawm Ntawv)
 - Women, Infants, and Children Program (WIC) (Tsev Mis)
 - Bureau of Indian Affairs General Assistance (BIA GA)
 - Temporary Assistance for Needy Families (TANF) lossis Tribal TANF
 - Head Start Income Eligible - Tribal Only
 - Food Stamps / SNAP (Nyiaj Muas Noj)

- 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 tag nrho Sawvdaws uake) yog tau li cas? ▼

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Yog tias tau ntau tshaj \$59,600, sau rau ntawm no: \$, .00 tauj ib xyoo

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

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



SEMPRA ENERGY utility

ក្រដាសដាក់សុំការចុះតម្លៃ ២០ ភាគរយ នៃកម្មវិធីវិយែរ (CARE)

កម្មវិធីនៃតម្លៃថាមពលធានារដ្ឋកាលីហ្វ័រញ៉ា (California Alternate Rates for Energy - CARE) របស់ក្រុមហ៊ុន The Gas Company ផ្តល់ជាការចុះតម្លៃ 20% នៃការចុះតម្លៃចំពោះសំបុត្រ ទារលុយសំរាប់ផ្ទះសំបែងណាដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីនេះ ។ លោកអ្នកដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន ហើយត្រូវបានអនុញ្ញាតក្នុងកំឡុង 90 ថ្ងៃនៃការចាប់ផ្តើមសេវាកម្មហ្គាសថ្មី ក៏នឹងទទួលបានការចុះតម្លៃ \$15 នៃតម្លៃតម្លើងស្ថាបនា សេវាកម្ម (Service Establishment Charge) ។ ការចុះតម្លៃ នឹងអនុវត្ត ពេលលោកអ្នកបំពេញ និង ចុះហត្ថលេខាក្រដាសសុំនេះ ត្រូវបានសំរេចដោយ ក្រុមហ៊ុន The Gas CompanySM។

សូមបំពេញក្រដាសសុំ ហើយផ្ញើវាមកវិញនៅក្នុងស្រោមសំបុត្រ ដែលបានផ្តល់ជូនដល់ វិស្វកម្មអ៊ីនធឺណិតតាម <http://www.socalgas.com/assistance/care/>

មធ្យោបាយដើម្បីនឹងមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានសំរាប់ការចុះតម្លៃ :

កម្មវិធីជំនួយសាធារណៈ:
បើលោកអ្នក ឬនរណាម្នាក់ទៀតនៅក្នុងផ្ទះរបស់លោកអ្នក ចូលរួមកម្មវិធីណាមួយដូចតទៅ :
មេឌីខេត មេឌីខាល សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B ស្ត្រី ទារក ហើយនិង កុមារ (WIC)
តែនហ្វូ (TANF) ទ្រឹបដល់តែនហ្វូ (Tribal TANF)
សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច
ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance)
ប្រាក់ភ្នាក់ងារស្នើម្នាក់ (SNAP)
កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch Program - NSLP)
កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
ចំណូលសេដ្ឋកិច្ចបន្ថែម (Supplemental Security Income - SSI)

ឬ

ចំណូលគ្រួសារអតិបរមា *:	
<i>(មានប្រសិទ្ធភាពនៅក្នុងថ្ងៃទី 1 មិថុនា 2010 ដល់ថ្ងៃទី 31 ឧសភា 2011)</i>	
*ចំណូលគ្រួសារបច្ចុប្បន្នមកពីប្រភពទាំងអស់មិនពេលកាត់ទុក	
ចំនួនមនុស្សរស់នៅក្នុងផ្ទះ:	ចំនួនថវិកាប្រៀបធៀប
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
សំរាប់ចំនួនសមាជិកនៃផ្ទះបន្ថែមម្នាក់ បញ្ចូល	\$7,600

លក្ខខណ្ឌចំពោះការចូលរួម

សំបុត្រទារលុយហ្គាសត្រូវតែមានឈ្មោះ និងអាសយដ្ឋានរបស់លោកអ្នក ហើយត្រូវតែមានអាយុដ្ឋានចំបងរបស់លោកអ្នក ។ / លោកអ្នកមិនត្រូវធ្វើដាក់ ឈ្មោះកូនកូនបិតនៅក្នុងបន្ទប់សំអាងទៅលើទឹកនៃនរណាម្នាក់ទៀត ជាជាងប្រពន្ធឬប្តីរបស់លោកអ្នកឡើយ ។ / លោកអ្នកត្រូវតែដាក់ស្នើសុំការបញ្ជាក់ម្តង ទៀតចំពោះក្រដាសសុំរបស់លោកអ្នកនៅពេល ស្នើសុំ ។ / លោកអ្នកត្រូវតែប្រាប់ក្រុមហ៊ុន The Gas Company អោយដឹងយ៉ាងហោចណាស់ 30 ថ្ងៃ បើ លោកអ្នកពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន ។ / លោកអ្នកប្រហែល ជាត្រូវបានស្នើសុំអោយបញ្ជាក់នូវលក្ខណៈគ្រប់គ្រាន់ទទួលបាន CARE របស់លោកអ្នក។

កម្មវិធី និងសេវាកម្មទៀត ដែលលោកអ្នកមានលក្ខណៈគ្រប់គ្រាន់នឹងទទួលបាន :

ដាប (DAP) – កម្មវិធីនៃជំនួយផ្ទាល់ (Direct Assistance Program) ជាកម្មវិធីសំរាប់ការប្រើប្រាស់ថាមពលដែលមានប្រសិទ្ធភាពទាប ផ្តល់ជាកម្មវិធីនៃការសន្សំថាមពលនៅក្នុងផ្ទះ ដោយមិនអស់លុយដូចជាការដាក់ទ្រនាប់នៅលើធាតុ បន្ទះបិទបង្ហាញធាតុ អាកាស តាមចន្លោះទ្វារ ការបិទថ្នាំការបិទ និងការជួសជុលតិចតួចនៃផ្ទះសំបែង។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-800-331-7593។

ម៉ាឌីខាល បេសឡាញ (Medical Baseline) – ផ្តល់ជាប្រាក់ ជំនួយខាងហ្គាសដោយមានតម្លៃថែទាំចំពោះអ្នកទិញ ដែលមានលក្ខខណ្ឌសុខភាពជាក់លាក់។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទ លេខ 1-800-427-2200។

លីហ្គេប (LIHEAP) – កម្មវិធីជំនួយខាងថាមពលនៃផ្ទះសំបែង ដែលមានថវិកាតិច ផ្តល់ជាកម្មវិធីនៃការសំបុត្រទារលុយ ជំនួយខាងសំបុត្រទារលុយបន្តាន់ ហើយនិងសេវាកម្មខាងរំដោះធាតុអាកាស ។ ទូរស័ព្ទ ក្រសួងសេវាកម្មសហគមន៍រដ្ឋកាលីហ្វ័រញ៉ា (California Dept. of Community Services and Development) លេខ 1-866-675-6623 ។

ខ្សែនៃជីវិតរដ្ឋកាលីហ្វ័រញ៉ា California Lifeline – លទ្ធភាពចំពោះទូរស័ព្ទដោយមានតម្លៃថែទាំ សំរាប់អ្នកទិញដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន បំពេញតាមការណែនាំពីចំណូលរបស់ CARE។ សំរាប់ព័ត៌មានបន្ថែម សូមទាក់ទងអ្នកផ្តល់សេវាកម្មខាងទូរស័ព្ទប្រចាំស្រុករបស់លោកអ្នក ។

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



Sempra Energy utility

ក្រដាសដាក់ពាក្យសុំចុះតម្លៃ 20% នៃកម្មវិធី CARE

សូមប្រើទឹកបិទខ្មៅ ហើយសរសេរដោយច្បាស់ឆ្លុះឆ្លាំងដើម្បីបញ្ជាក់ដំណើរការយ៉ាងត្រឹមត្រូវ
វិធីត្រឹមត្រូវក្នុងការគូសរង្វង់មូល: ●

Form 6491-C KH (06/10)

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

1

ឈ្មោះរបស់អ្នកទិញ (ដូចមានលើសំបុត្រទារលុយ):

អាសយដ្ឋាន (រដ្ឋ ក្រុង កូដឥសាន):

លេខគណនី:

លេខទូរស័ព្ទ: () -

អាសយដ្ឋានអ៊ីមែល:

2

សរុបចំនួនជនពេញវ័យ និងក្មេងក្នុងគ្រួសាររបស់លោកអ្នក: 1 2 3 4 5 6 6+:

តើលោកអ្នក (វិនិច្ឆ័យក្នុងគ្រួសាររបស់លោកអ្នក) ចូលរួមក្នុងកម្មវិធីជំនួយណាមួយខាងក្រោមរឺទេ?

មាន បើមាន សូមគូសកម្មវិធីចូលរួម និងតទៅសំណួរទី 3) ▼

- មេឌីខេត/មេឌីខាល: ក្រោម 65 ឆ្នាំ
- មេឌីខេត/មេឌីខាល: 65 ឆ្នាំ រឺលើសនេះ
- សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
- កម្មវិធីស្ត្រី ទារក ហើយនិង កុមារ (WIC)
- ជំនួយបណ្តោះអាសន្នសម្រាប់គ្រួសារដែលត្រូវការ (TANF) រឺទ្រូបលំផែនហ្វូ (Tribal TANF)
- ប្រាក់កូតស្តែមស៍/SNAP
- កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
- ចំណូលសេកុរីទីបន្ថែម (Supplemental Security Income - SSI)
- កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch Program - NSLP)
- ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌូ (Bureau of Indian Affairs General Assistance - BIA GA)
- សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច

មិនមាន (បើមិនមាន សូមតទៅសំណួរខាងក្រោម) ▶

បើលោកអ្នកមិនចូលរួមនៅក្នុងកម្មវិធីណាមួយដែលបានបរិយាយនៅខាងលើទេ តើចំណូលគ្រួសារប្រចាំឆ្នាំរបស់លោកអ្នក (មុនពេលកាត់ រួមសមាជិកគ្រួសារទាំងអស់) មានប៉ុន្មាន? ▼

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

បើច្រើនជាង \$59,600 ដាក់បញ្ចូលចំនួនកន្លែងនេះ: \$, .00 ក្នុងមួយឆ្នាំ

គូសយកប្រភពចំណូលរបស់លោកអ្នក: ▼

- សូស្យាល់សេកុរីទី
- SSP រឺ SSDI
- លុយរឹត្រួត
- ការប្រាក់ ឬភាគលាភពី: គណនីសន្សំ ប្រាក់ Stocks, Bonds រឺលុយរឹត្រួត
- ប្រាក់ខែ និង/ឬប្រាក់ចំណេញពីពាណិជ្ជកម្មផ្ទាល់ខ្លួន
- ប្រាក់អត្ថប្រយោជន៍ពីការឥតការធ្វើ
- ប្រាក់មកពីអនិស្សន្ទ រឺប្រាក់មកពីការកាត់សេចក្តី
- ប្រាក់ពីការ រឺសំណងកម្មករ
- ប្រាក់ជំនួយពីប្តីឬប្រពន្ធ រឺជំនួយកូន
- ប្រាក់ជំនួយអាហាររូបករណ៍ ជំនួយរឺជំនួយឡើងប្រើសំរាប់ការថាយវាយក្នុងជីវភាព
- ប្រាក់មកពីការជួល រឺស្តាយសារ
- ប្រាក់សុទ្ធ /ឬថវិកាទៀត

3

តើលោកអ្នកព្រមចំពោះការរៀបរាប់ខាងក្រោមទេ? សូមអាន ហើយចុះហត្ថលេខាខាងក្រោម ។

ខ្ញុំសូមថ្លែងថាព័ត៌មានដែលខ្ញុំបានផ្តល់នៅក្នុងក្រដាសដាក់សុំនេះ គឺពិតហើយត្រឹមត្រូវ ។ ខ្ញុំយល់ព្រមនឹងផ្តល់នូវភស្តុតាងសំរាប់លក្ខណៈគ្រប់គ្រាន់ទទួលបាន CARE ប្រសិនបើខ្ញុំ បានស្នើសុំ ។ ខ្ញុំយល់ព្រមនឹងប្រាប់ក្រុមហ៊ុន The Gas Company ប្រសិនបើខ្ញុំមានលក្ខណៈគ្រប់គ្រាន់និងទទួលបានការចុះថែកនេះ ។ ខ្ញុំយល់ថា បើខ្ញុំទទួលបានការចុះ ថែកដោយមិនមានលក្ខណៈគ្រប់គ្រាន់ទទួល ខ្ញុំអាចត្រូវបានផ្សំរឺដោយបង់សងការចុះថែកដែលខ្ញុំបានទទួល ។ ខ្ញុំយល់ថា ក្រុមហ៊ុន The Gas Company អាចចែកចាយព័ត៌មានរបស់ខ្ញុំជាមួយនិងក្រុមហ៊ុន និងភ្នាក់ងាររាជធានីដើម្បីចុះឈ្មោះខ្ញុំនៅក្នុងកម្មវិធីជំនួយរបស់គេ ។

ហត្ថលេខា: X ថ្ងៃខែ: / /



ЗАЯВЛЕНИЕ НА 20% СКИДКУ ПО ПРОГРАММЕ CARE

Программа Калифорнийской газовой компании по альтернативным тарифным ставкам за пользование энергоресурсами (программа CARE) предоставляет 20% скидку с суммы ежемесячного счета за газ для правомочных семей. Клиенты, имеющие право и получившие утверждение Компании в течение 90 дней с начала новой услуги по газоснабжению, получают от Компании также скидку в размере 15 долларов. Скидка начнет действовать после того, как поданное и подписанное вами заявление будет утверждено компанией The Gas CompanySM.

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, Общее пособие Бюро по делам индейцев, Продовольственные талоны (SNAP), Государственная программа бесплатных завтраков в школе (NSLP), Программа пособий на отопление жилья для малоимущих (LIHEAP), Добавочные пособия малоимущим (SSI)

ИЛИ

ВАШ ОБЩИЙ СЕМЕЙНЫЙ ДОХОД НЕ ПРЕВЫШАЕТ*: <i>(имеет силу в период с 1 июня 2010г. по 31мая 2011г.)</i> *совокупный семейный доход из всех источников до любых вычетов	
Кол-во членов семьи	Общий годовой доход
1-2	31 300 \$
3	36 800 \$
4	44 400 \$
5	52 000 \$
6	59 600 \$
За каждого дополнительного члена семьи добавьте	7 600 \$

УСЛОВИЯ ДЛЯ УЧАСТИЯ В ПРОГРАММЕ

Счет за пользование газом должен быть оформлен на ваше имя и приходиться на ваш официальный адрес. / Вы не оформлены иждивенцем в налоговой декларации какого-либо другого лица 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 ИМЕТЬ ПРАВО:

DAP: Программа прямой помощи (Direct Assistance Program) – это программа по увеличению эффективности использования энергоресурсов для малообеспеченных семей. Она предлагает бесплатные услуги по ремонту, такие как теплоизоляция потолков, герметизация дверных прокладок, уплотнение внутренних стыков и небольшие ремонтные работы. За дополнительной информацией обращайтесь по телефону 1-800-331-7593.

Medical Baseline: Данная программа дополнительно предоставляет увеличение допустимого 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 заявления на 20% скидку по программе CARE

Form 6491-C RU (06/10)
THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Для правильной обработки заявления пишите темными чернилами и печатными буквами

1	Имя и фамилия клиента (как на счете):	<input type="text"/>
	Домашний адрес (номер дома, улица, номер квартиры, город, штат, почтовый индекс):	<input type="text"/>
	Номер счета:	<input type="text"/>
	Номер телефона: () -	<input type="text"/>
	Адрес электронной почты:	<input type="text"/>

2	Число членов вашей семьи (включите себя, всех взрослых и детей):	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> Более 6: <input type="text"/>
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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)
- Добавочные пособия малоимущим (SSI)
- Государственная программа бесплатных завтраков в школе (NSLP)
- Общее 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, каков ваш совокупный семейный доход (до всех вычетов, включая доходы всех членов семьи, проживающих с вами). ▼

- \$0 - \$31 300
- \$31 301 - \$36 800
- \$36 801 - \$44 400
- \$44 401 - \$52 000
- \$52 001 - \$59 600

Если ваш доход превышает 59 600 долл., то укажите здесь его размер: \$,00 в год

Укажите 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. деятельности
- Пособие по безработице
- Страховые выплаты и выплаты по искам
- Пособие по инвалидности и компенсации за травмы на работе
- Пособие на супруга или на детей
- Стипендии, гранты и иные компенсации на проживание
- Доходы от аренды или лицензионные поступления
- Выплаты наличными или иной 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 обещаю по требованию предъявить доказательства моей правомочности на программу CARE. Я обещаю 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 выплаты 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: <input checked="" type="checkbox"/> _____ Дата: <input type="text"/> / <input type="text"/> / <input type="text"/>

**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 kwalipikado at naaprubahan sa loob ng 90 araw mula sa pag-uumpisa ng bagong serbisyong gas ay tatanggap din ng \$15 na diskuwento sa Service Establishment Charge. Ibibigay ang diskuwento kapag naaprubahan ng The Gas CompanySM 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 Families A&B
Women, Infants & Children (WIC)
TANF, Tribal TANF
Head Start Income Eligible – Tribal Lamang
Bureau of Indian Affairs General Assistance
Food Stamps (SNAP)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program (LIHEAP)
Supplemental Security Income (SSI)

O

MGA HANGGANAN NG KITA NG SAMBAHAYAN*: (<i>may-bisa Hunyo 1, 2010 hanggang Mayo 31, 2011</i>) *kasalukuyang kita ng sambahayan mula sa lahat ng pinagkukunan bago mga kabawasan	
Bilang ng Tao sa Sambahayan	Kabuuang Kita para sa Taon
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Para sa bawat karagdagang miyembro ng sambahayan, magdagdag ng	\$7,600

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 pamamagitan ng telepono na may diskuwento, para sa mga mamimiling ang kita ay tumatalima sa mga kagayang tuntunin ng CARE hinggil sa kita. Upang makatanggap ng karagdagang impormasyon, makipag-alam sa inyong lokal na tagapaglaan ng serbisyo sa telepono.

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



**Application para sa
CARE 20% Diskuwentong 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 (06/10)
THE GAS COMPANY
CARE PROGRAM, ML GT12F1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1

Pangalan ng Mamimili
(gaya ng nakalista sa inyong 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
 Kung higit sa 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) ▼

<ul style="list-style-type: none"> <input type="radio"/> Medi-Cal / Medicaid: Mas mababa kaysa Edad 65 <input type="radio"/> Medi-Cal / Medicaid: 65 o higit <input type="radio"/> Healthy Families - mga kategoriya A & B <input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Temporary Assistance for Needy Families (TANF) o Tribal TANF <input type="radio"/> Food Stamps / SNAP 	<ul style="list-style-type: none"> <input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP) <input type="radio"/> Supplemental Security Income (SSI) <input type="radio"/> National School Lunch Program (NSLP) <input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA) <input type="radio"/> Head Start Income Eligible - Tribal Lamang
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HINDI (Kung hindi, mangyaring magpatuloy sa mga sumusunod na tanong) ►

Kung sa kasalukuyan 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 - \$31,300
 \$31,301 - \$36,800
 \$36,801 - \$44,400
 \$44,401 - \$52,000
 \$52,001 - \$59,600

Kung higit sa \$59,600, ilagay ang halaga dito: \$, .00 bawat taon

Pakisuyong markahan ang inyong mga pinagkukunan ng kita: ▼

<ul style="list-style-type: none"> <input type="radio"/> Social Security <input type="radio"/> SSP o SSDI <input type="radio"/> Mga Pensiyon <input type="radio"/> Mga Interes o Dibidendo galing sa: Savings, Stocks, Bonds, o mga Retirement Account 	<ul style="list-style-type: none"> <input type="radio"/> Mga Suweldo at/o Kita galing sa Self Employment <input type="radio"/> Mga Unemployment Benefit <input type="radio"/> Mga Insurance o Legal Settlement <input type="radio"/> Mga Kabayaran galing sa Disability o Workers Compensation 	<ul style="list-style-type: none"> <input type="radio"/> Spousal o Child Support <input type="radio"/> Mga scholarship, grant, o ibang tulong na ginagamit sa mga gastos pambuhay <input type="radio"/> Rental o Royalty Income <input type="radio"/> Kuwarta o Ibang Kita
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3

Sumasang-ayon ba kayo sa mga sumusunod? Mangyaring basahin at lumagda sa ibaba.

Isinasaad ko na ang impormasyong aking ibinigay sa application na ito ay tapat at tumpak. Sumasang-ayon ako na kung ako ay hihilingan, papatunayan ko na ako'y karapat-dapat sa CARE. Sumasang-ayon 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 ibang utility o mga ahente upang matala ako sa kanilang mga programang nagbibigay ng tulong.

Lagda: **Petsa:** / /

**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 CompanySM

กรุณากรอกใบสมัครให้ครบถ้วนและส่งคืนโดยใช้ซองที่ให้เรา หรือสมัครออนไลน์ได้ที่

<http://www.socalgas.com/assistance/care/>

วิธีในการผ่านเกณฑ์สำหรับการรับส่วนลด THE CARE DISCOUNT:

โครงการความช่วยเหลือสาธารณะ: (PUBLIC ASSISTANCE PROGRAMS)	รายได้รวมสูงสุดของครัวเรือน*: (มีผลตั้งแต่ 1 มิถุนายน 2010 ถึง 31 พฤษภาคม 2011) *รายได้รวมของครัวเรือนจากทุกแหล่งรายได้ ก่อนการหัก ค่าใช้จ่าย															
<p>ในกรณีที่ท่านหรือสมาชิกในครอบครัวได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้:</p> <p>ความช่วยเหลือทางการแพทย์, ค่ารักษาพยาบาล, สุขภาพของครอบครัว A&B, โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC), โครงการช่วยเหลือการเงินชั่วคราวสำหรับครอบครัวที่ขาดแคลน (TANF), กลุ่มTANF, โครงการ Head Start เพื่อช่วยเหลือเด็กและครอบครัวที่มีรายได้น้อย เฉพาะกลุ่ม, สำนักงานให้ความช่วยเหลือทั่วไปสำหรับอเมริกันอินเดียน (Bureau of Indian Affairs General Assistance), โปรแกรมสแตมป์อาหารสำหรับผู้มีรายได้น้อย (SNAP), โปรแกรมอาหารกลางวันฟรีแห่งชาติสำหรับโรงเรียน (NSLP), โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP), โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)</p>	หรือ	<table border="1"> <thead> <tr> <th>จำนวนสมาชิก ในครัวเรือน</th> <th>รายได้รวม ต่อปี</th> </tr> </thead> <tbody> <tr> <td>1-2</td> <td>\$31,300</td> </tr> <tr> <td>3</td> <td>\$36,800</td> </tr> <tr> <td>4</td> <td>\$44,400</td> </tr> <tr> <td>5</td> <td>\$52,000</td> </tr> <tr> <td>6</td> <td>\$59,600</td> </tr> <tr> <td>หากมีสมาชิกในครัวเรือน เพิ่มขึ้น 1 คน, ให้เพิ่มอีกคนละ</td> <td>\$7,600</td> </tr> </tbody> </table>	จำนวนสมาชิก ในครัวเรือน	รายได้รวม ต่อปี	1-2	\$31,300	3	\$36,800	4	\$44,400	5	\$52,000	6	\$59,600	หากมีสมาชิกในครัวเรือน เพิ่มขึ้น 1 คน, ให้เพิ่มอีกคนละ	\$7,600
จำนวนสมาชิก ในครัวเรือน	รายได้รวม ต่อปี															
1-2	\$31,300															
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5	\$52,000															
6	\$59,600															
หากมีสมาชิกในครัวเรือน เพิ่มขึ้น 1 คน, ให้เพิ่มอีกคนละ	\$7,600															

ข้อกำหนดสำหรับผู้เข้าร่วมโครงการ

ใบเรียกเก็บเงินค่าบริการก๊าซต้องเป็นชื่อของท่านและที่อยู่ต้องเป็นที่อยู่หลักของท่าน / ท่านต้องไม่ใช่สิทธิ์เป็นผู้อยู่ในความดูแล (Dependent) ของผู้อื่น นอกเหนือจากคู่สมรสของท่านในการเสียภาษีรายได้ / ท่านต้องแสดงหลักฐานตามที่ระบุไว้ในใบสมัครอีกครั้ง หากมีการร้องขอ / ท่านต้องแจ้งให้ The Gas Company ทราบภายใน 30 วัน หากท่านขาดสถานะสภาพในการเข้าร่วมโครงการ / ท่านอาจถูกร้องขอให้แสดงหลักฐานยืนยันว่าท่านมีสิทธิ์ในการเข้าร่วมโครงการ CARE

โครงการและบริการอื่นๆ ที่ท่านอาจผ่านเกณฑ์ในการเข้าร่วม:

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

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

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

California Lifeline: (โครงการส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยของรัฐแคลิฟอร์เนีย) โครงการนี้จะมอบส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยในเกณฑ์เดียวกับผู้มีสิทธิ์เข้าร่วมโครงการ CARE ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้จากผู้ให้บริการโทรศัพท์ในท้องถิ่นของท่าน

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



ใบสมัคร CARE 20% Rate Discount

Form 6491-C TH (06/10)

กรุณากรอกข้อมูลให้ครบถ้วนด้วยตัวบรรจง โดยใช้หมึกสีเข้ม

ฝนทำเครื่องหมายวงกลม: ●

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

1	ชื่อลูกค้า (ตามใบแจ้งหนี้): <input type="text"/> ที่อยู่ (ถนน, เมือง, รหัสไปรษณีย์): <input type="text"/> หมายเลขบัญชี: <input type="text"/> หมายเลขโทรศัพท์: (<input type="text"/>) <input type="text"/> - <input type="text"/> อีเมล: <input type="text"/>
2	<p>จำนวนสมาชิกทั้งหมดในครัวเรือนของท่าน: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 6+ : <input type="text"/></p> <p>ท่าน (หรือสมาชิกในครัวเรือนของท่าน) ได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้หรือไม่?</p> <p><input type="radio"/> ใช่ (ถ้าใช่, ให้ทำเครื่องหมายหน้าโปรแกรมที่เข้าร่วม และไปยังคำถามข้อที่ 3)▼</p> <ul style="list-style-type: none"> <input type="radio"/> Medi-Cal / Medicaid: อายุน้อยกว่า 65 ปี <input type="radio"/> Medi-Cal / Medicaid: อายุ 65 ปีขึ้นไป <input type="radio"/> โปรแกรมสุขภาพของครอบครัว A & B <input type="radio"/> โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC) <input type="radio"/> โครงการช่วยเหลือการเงินชั่วคราวสำหรับครอบครัวที่ขาดแคลน (TANF), กลุ่ม TANF <input type="radio"/> โปรแกรมสแตมป์อาหารสำหรับผู้มีรายได้น้อย / SNAP <input type="radio"/> โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP) <input type="radio"/> โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI) <input type="radio"/> โปรแกรมอาหารกลางวันฟรีแห่งชาติสำหรับโรงเรียน (NSLP) <input type="radio"/> สำนักงานให้ความช่วยเหลือทั่วไปต่ออเมริกันอินเดียน (BIA GA) <input type="radio"/> โครงการ Head Start เพื่อช่วยเหลือเด็กและครอบครัวที่มีรายได้น้อย-เฉพาะชนเผ่า <p><input type="radio"/> ไม่ใช่ (ถ้าไม่ใช่, ให้ตอบคำถามดังต่อไปนี้)▶</p> <p>หากท่านไม่ได้ร่วมโครงการใดๆ ที่ระบุไว้ข้างต้น, รายได้ของครัวเรือนต่อปีของท่านเท่าไร? (ก่อนหักค่าใช้จ่าย, รวมทั้งสมาชิกในครัวเรือนทุกคน)? ▼</p> <p><input type="radio"/> \$0 - \$31,300 <input type="radio"/> \$31,301 - \$36,800 <input type="radio"/> \$36,801 - \$44,400 <input type="radio"/> \$44,401 - \$52,000 <input type="radio"/> \$52,001 - \$59,600</p> <p><input type="radio"/> หากรายได้ของท่านมากกว่า \$59,600, โปรดระบุจำนวนรายได้ที่นี้: \$ <input type="text"/>, <input type="text"/>.00 ต่อปี</p> <p>กรณารายได้: ▼</p> <ul style="list-style-type: none"> <input type="radio"/> เงินประกันสังคม <input type="radio"/> SSP หรือ SSDI <input type="radio"/> เงินบำนาญ <input type="radio"/> ดอกเบี้ยเงินฝาก หรือเงินปันผล จาก: บัญชีออมทรัพย์, หุ้น, พันธบัตร, หรือบัญชีสำหรับผู้เกษียณ <input type="radio"/> ค่าจ้าง และ/หรือ กำไรจากอาชีพอิสระ <input type="radio"/> สิทธิผลประโยชน์จากการว่างงาน <input type="radio"/> เงินประกันหรือเงินที่ได้จากการชำระหนี้ตามกฎหมาย <input type="radio"/> เงินชดเชยทุพพลภาพ หรือเงินชดเชยแรงงาน <input type="radio"/> เงินช่วยเหลือคู่สมรสหรือบุตร <input type="radio"/> ทูน, เงินสนับสนุน, หรือเงินช่วยเหลืออื่นๆ ที่ใช้ในการครองชีพ <input type="radio"/> ค่าเช่าหรือรายได้จากค่าลิขสิทธิ์ <input type="radio"/> เงินสด หรือรายได้อื่นๆ
3	<p>ท่านเห็นด้วยกับข้อความต่อไปนี้หรือไม่? กรุณาอ่านและลงนามด้านล่าง</p> <p>ข้าพเจ้ารับรองว่าข้อมูลที่ข้าพเจ้าระบุในเอกสารใบสมัครฉบับนี้ถูกต้องและเป็นความจริง หากมีการร้องขอ ข้าพเจ้ายินยอมที่จะแสดงหลักฐานที่แสดงว่าข้าพเจ้ามีสิทธิ์เข้าร่วมโครงการ CARE ข้าพเจ้าตกลงจะแจ้ง The Gas Company ทันทีที่ข้าพเจ้าขาดสภาพในการได้รับส่วนลดจากโครงการ ข้าพเจ้าตกลงว่า หากข้าพเจ้าได้รับส่วนลดโดยที่ข้าพเจ้าไม่ผ่านเกณฑ์ในการเข้าร่วมโครงการ ข้าพเจ้าอาจต้องจ่ายคืนส่วนลดที่ข้าพเจ้าได้รับ ข้าพเจ้าตกลงว่า The Gas Company สามารถเปิดเผยข้อมูลของข้าพเจ้ากับเจ้าหน้าที่หรือบริษัทสาธารณูปโภคอื่นๆ เพื่อลงทะเบียนข้าพเจ้าในโครงการช่วยเหลืออื่นๆ ได้</p> <p>ลายเซ็น: X <input type="text"/> วันที่: <input type="text"/> / <input type="text"/> / <input type="text"/></p>

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Individually Metered Residential (Form No. 6674-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H6

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



YOUR RATE DISCOUNT IS EXPIRING



Dear Customer:

Date: 06/01/2010

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 the 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 Program (NSLP), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective June 1, 2010 to May 31, 2011)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Each additional household member, add	\$7,600

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:



A Sempra Energy utility

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 (06/10)

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 Program (NSLP)
- 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, 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:

Date: ____ / ____ / ____

DATE : 06 / 01 / 2010

**EL DESCUENTO EN SU
TARIFA ESTÁ POR VENCER**

Apreciable cliente:

Fecha: 06/01/2010

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.
-
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,
-
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
Healthy Families 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)
National School Lunch Program (NSLP)
Agencia de Asuntos Indios, Asistencia General (BIA GA)
Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

○

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2010 al 31 de mayo de 2011)
 *ingreso actual en el hogar de todas las fuentes antes de deducciones

Número de personas en el hogar	Ingreso total anual
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Por cada miembro adicional en el hogar, añada	\$7,600

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 (06/10)

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	<p>Nombre del cliente (tal como aparece en su factura):</p> <p>Domicilio:</p> <p>Número de cuenta:</p> <p>Teléfono: () -</p> <p>E-mail:</p>																								
<p><input type="radio"/> 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.</p>																									
2	<p>Número total de adultos y niños que viven en su hogar: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> si más de 6: <input type="text"/></p> <p>¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?</p> <p><input type="radio"/> SÍ (Si su respuesta es afirmativa, marque el(los) programa(s) de participación, y vaya a la pregunta 3) ▼</p> <table border="0"> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: menor de 65 años</td> <td><input type="radio"/> Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)</td> </tr> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: 65 años o más</td> <td><input type="radio"/> Ingreso Suplementario del Seguro Social (SSI)</td> </tr> <tr> <td><input type="radio"/> Healthy Families Categorías A & B</td> <td><input type="radio"/> National School Lunch Program (NSLP)</td> </tr> <tr> <td><input type="radio"/> Programa para Mujeres, Infantes, y Niños (WIC)</td> <td><input type="radio"/> Agencia de Asuntos Indios, Asistencia General (BIA GA)</td> </tr> <tr> <td><input type="radio"/> Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal</td> <td><input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal</td> </tr> <tr> <td><input type="radio"/> Cupones para alimentos / SNAP</td> <td></td> </tr> </table> <p><input type="radio"/> NO (Si su respuesta es negativa, por favor continúe con las siguientes preguntas) ►</p> <p>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)? ▼</p> <p><input type="radio"/> \$0 - \$31,300 <input type="radio"/> \$31,301 - \$36,800 <input type="radio"/> \$36,801 - \$44,400 <input type="radio"/> \$44,401 - \$52,000 <input type="radio"/> \$52,001 - \$59,600</p> <p><input type="radio"/> Si es más de \$59,600, escriba el monto aquí : \$,.00 al año</p> <p>Por favor marque sus fuentes de ingreso: ▼</p> <table border="0"> <tr> <td><input type="radio"/> Seguro Social</td> <td><input type="radio"/> Salarios y/o ingresos de autoempleo</td> <td><input type="radio"/> Pensión conyugal o alimenticia</td> </tr> <tr> <td><input type="radio"/> SSP o SSDI</td> <td><input type="radio"/> Beneficios de desempleo</td> <td><input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida</td> </tr> <tr> <td><input type="radio"/> Pensiones</td> <td><input type="radio"/> Pagos de pólizas de seguro o convenios judiciales</td> <td><input type="radio"/> Ingresos por alquiler o regalías</td> </tr> <tr> <td><input type="radio"/> Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro</td> <td><input type="radio"/> Pagos por incapacidad o Indemnización para los trabajadores</td> <td><input type="radio"/> Dinero en efectivo y/u otros ingresos</td> </tr> </table>	<input type="radio"/> Medi-Cal / Medicaid: menor de 65 años	<input type="radio"/> Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)	<input type="radio"/> Medi-Cal / Medicaid: 65 años o más	<input type="radio"/> Ingreso Suplementario del Seguro Social (SSI)	<input type="radio"/> Healthy Families Categorías A & B	<input type="radio"/> National School Lunch Program (NSLP)	<input type="radio"/> Programa para Mujeres, Infantes, y Niños (WIC)	<input type="radio"/> Agencia de Asuntos Indios, Asistencia General (BIA GA)	<input type="radio"/> Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal	<input type="radio"/> Cupones para alimentos / SNAP		<input type="radio"/> Seguro Social	<input type="radio"/> Salarios y/o ingresos de autoempleo	<input type="radio"/> Pensión conyugal o alimenticia	<input type="radio"/> SSP o SSDI	<input type="radio"/> Beneficios de desempleo	<input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida	<input type="radio"/> Pensiones	<input type="radio"/> Pagos de pólizas de seguro o convenios judiciales	<input type="radio"/> Ingresos por alquiler o regalías	<input type="radio"/> Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro	<input type="radio"/> Pagos por incapacidad o Indemnización para los trabajadores	<input type="radio"/> Dinero en efectivo y/u otros ingresos
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3	<p>¿Acepta usted lo siguiente? Por favor lea y firme abajo.</p> <p>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.</p> <p>Firma: <input checked="" type="checkbox"/> Fecha : / /</p>																								

DATE: 06/01/2010



A Sempra Energy utility

**您的費率折扣
即將過期**

親愛的客戶：

日期：06/01/2010

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/，請準備好您的帳戶號碼。

符合 CARE 折扣的兩種資格：

政府協助計劃:
如果您或您的家人從下列任一計劃中受益： 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 Program (NSLP, 全國學童午餐計劃)、Low Income Home Energy Assistance Program (LIHEAP, 低收入家庭能源協助計劃)、Supplemental Security Income (SSI, 社會安全補助金)

或

家庭收入最高限額*: (有效期 2010 年 6 月 1 日至 2011 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	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
每多一位家庭成員，增加	\$7,600

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。

若需更多關於 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

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

帳戶號碼：



A Sempra Energy utility

CARE 20% 費率折扣資格重新認證表格

請用深色筆以正楷填寫清晰以確保適當受理
正確塗圈方法：●

Form 6674-C CH (06/10)

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:

我不再符合或不願再參加 CARE 計劃。請把我的帳戶從 CARE 計劃中取消。

- ← 如果您將這個圓圈塗黑(●), 請直接填寫第 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:

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) ▼

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

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 (稅前收入, 包括所有家庭成員), 把適當項目前的圓圈塗黑: ▼

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

如果多於 \$59,600, 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: ▼

- | | | |
|--|---------------------------------|--|
| <input type="radio"/> 社會安全福利金 Social Security | <input type="radio"/> 工資或薪金 | <input type="radio"/> 配偶或子女支付的贍養費 |
| <input type="radio"/> 社會安全輔助金 SSP, SSDI | <input type="radio"/> 失業救濟金 | <input type="radio"/> 獎學金, 助學金, 或其它用於支付生活費用的助學津貼 |
| <input type="radio"/> 退休金 | <input type="radio"/> 保險或法律賠償 | <input type="radio"/> 租金或權利金收入 |
| <input type="radio"/> 從以下項目獲取的利息或紅利: 儲蓄帳戶, 股票, 債券, 或退休帳戶 | <input type="radio"/> 殘疾津貼或勞工補償 | <input type="radio"/> 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: 日期: / /

DATE: 06/01/2010



귀하의 요금 할인이 종료됩니다

친애하는 고객님:

날짜: 06/01/2010

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 때나 전화하여 재증명 지시에 따르십시오. 좌번호를 준비하십시오. 귀하의 좌번호는 이 페이지 맨 아래에 있습니다.
또는
3. 구좌 번호를 갖추고 저의 웹사이트 www.socalgas.com/care/recert/ 를 방문하여 갱신에 임하실 수 있습니다.

CARE 할인 수혜 자격을 충족시키는 2 가지 방법이 있습니다:

공공 지원 프로그램:
<p>귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:</p> <p>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 Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)</p>

또는

최대 가구 소득*: (2010. 6. 1 부터 2011. 5. 31 까지 유효) *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
추가되는 식구 1 인당 추가액	\$7,600

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 광둥어: 1-800-427-1420 월남어: 1-800-427-0478
 청각 장애인(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)

구좌 번호:



Sempra Energy utility

CARE 20% 요금 할인 재증명 양식

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

Form 6674-C KO (06/10)

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 CARE에 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.) ▼

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

아니오 (아니오인 경우 다음 질문사항을 계속하십시오) ▼

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

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

\$59,600 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 \$, .00

귀하의 소득원에 표시하십시오: ▼

- | | | |
|---|--|--|
| <input type="radio"/> 사회보장금 | <input type="radio"/> 임금 그리고/또는 자영업 수익 | <input type="radio"/> 배우자 또는 자녀 부양비 |
| <input type="radio"/> SSP 또는 SSDI | <input type="radio"/> 실업 혜택 | <input type="radio"/> 장학금, 수여금, 또는 기타 생활 보조금 |
| <input type="radio"/> 연금 | <input type="radio"/> 보험금 또는 법적 타협금 | <input type="radio"/> 임대료나 로열티 소득 |
| <input type="radio"/> 저축, 주식, 채권, 또는 은퇴 구좌로 부터의 이자 또는 배당금 | <input type="radio"/> 장애 또는 산재 보상금 | <input type="radio"/> 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: 날짜: / /

DATE : 06/01/2010

**CHƯƠNG TRÌNH GIẢM GIÁ CỦA QUÝ VỊ SẴP HẾT HẠN**

Kính Gởi Quý Khách Hàng:

Ngày: 06/01/2010

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. Gửi 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, Chương trình 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), Bureau of Indian Affairs General Assistance, Food Stamps (SNAP), Chương trình Toàn quốc ăn Trưa Trường (NSLP), 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*: (có hiệu lực từ ngày 1 tháng Sáu, 2010 đến 31 tháng Năm, 2011) <small>*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình</small>	
Số Người trong Hộ Gia Đình	Tổng Lợi Tức Hàng Năm
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Thêm Mỗi người vào trong Gia Đình, cộng thêm	
	\$7,600

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 (06/10)

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

Sempira Energy utility®

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 gửi mẫu đơn này trong phong bì đã trả trả bưu 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 / Medicaid: Dưới 65 tuổi
 - Medi-Cal / Medicaid: 65 tuổi hoặc hơn
 - Gia Đình Khỏe Mạnh Loại A & B
 - Chương Trình Phụ Nữ Sơ Sinh và Trẻ Em (WIC)
 - Trợ Giúp Tạm Thời Cho Gia Đình có Nhu Cầu (TANF) hoặc TANF Bản Địa
 - Phiếu Thực Phẩm/SNAP
 - Trợ Giúp Năng Lượng Tại Gia Cho Người Lợi Tức Thấp (LIHEAP)
 - Trợ Cấp An Sinh (SSI)
 - Chương trình Toàn quốc ăn Trưa Trường (NSLP)
 - Bureau of Indian Affairs General Assistance
 - Đủ điều kiện lợi tức cho Head Start (Bản Địa mà thôi)

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Nếu nhiều hơn \$59,600, 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
- Lương và/hoặc Lợi tức Việc Làm Tự do
- Cấp dưỡng nuôi Con hoặc Phôi ngẫu
- SSP, SSDI
- Trợ cấp Thất nghiệp
- Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống
- Hưu bổng
- Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định
- Tiền Lừa hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí
- Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm
- 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 chứng 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, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H6

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



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 CompanySM.

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 Program (NSLP)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

← OR →

2 MAXIMUM HOUSEHOLD INCOME:

(effective June 1, 2010 to May 31, 2011)

Number of Persons in Household	Total Annual Income*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
For each additional household member, add \$7,600	

* 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



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 Program (NSLP)
- 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, 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: / /



FORMULARIO DE SOLICITUD PARA EL DESCUENTO CARE DEL 20%

A Sempra Energy utility®

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 CompanySM.

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
Healthy Families Categories 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
National School Lunch Program (NSLP)
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)



2 INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2010 al 31 de mayo de 2011)

Número de personas en el hogar	Ingreso total anual*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Por cada miembro adicional en el hogar, añada \$7,600	

* 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



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
- Healthy Families Categories 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)
- National School Lunch Program (NSLP)
- 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, 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
Post-Enrollment Verification CARE Application
Individually Metered Residential (Form No. 6675-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H6

ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



**IMMEDIATE REPLY
NEEDED**



Dear Customer:

Date: 06/01/2010

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 Program (NSLP), 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 Form 1099(s).
Insurance, Legal settlements	Settlement documents
Child and/or Spousal Support	Court Documents, or Copy of the Check
School Grants, Scholarships, or Other Aid	Award Letters, or two most recent consecutive Pay Stubs, or Copy of the Check
None of the Sources Above	A statement explaining the sources of income used to support your household

FOR INFORMATION ON CARE, CALL THE GAS COMPANYSM AT:

English:	1-800-427-2200	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 (06/10)

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.		<input type="radio"/>	<input type="radio"/>	6.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, 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:

DATE: 06/01/2010

**SE REQUIERE
RESPUESTA INMEDIATA**

Apreciable cliente:

Fecha: 06/01/2010

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, Healthy Families 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), National School Lunch Program (NSLP), 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 COMPANYSM 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)



Verificación para la tarifa CARE del 20% de descuento

Form 6675-C SP (06/10)

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: () () () () () () - () () () ()

E-mail: _____

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.		<input type="radio"/>	<input type="radio"/>	6.		<input type="radio"/>	<input type="radio"/>
2.		<input type="radio"/>	<input type="radio"/>	7.		<input type="radio"/>	<input type="radio"/>
3.		<input type="radio"/>	<input type="radio"/>	8.		<input type="radio"/>	<input type="radio"/>
4.		<input type="radio"/>	<input type="radio"/>	9.		<input type="radio"/>	<input type="radio"/>
5.		<input type="radio"/>	<input type="radio"/>	10.		<input type="radio"/>	<input type="radio"/>

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

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, 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) 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: _____

DATE: 06/01/2010



親愛的客戶：

日期: 06/01/2010

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 Program (全國學童午餐計劃)、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 (社會安全補助金)、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，兩份最近連續的補助金支票存根 (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

若需更多關於 CARE 計劃的資訊，請致電 THE GAS COMPANYSM：

英語：1-800-427-2200

國語：1-800-427-1429

西班牙語：1-800-342-4545

韓語：1-800-427-0471

粵語：1-800-427-1420

越南語：1-800-427-0478

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



CARE 計劃 20% 費率折扣確認表格

(請用深色筆以正楷填寫清晰以確保適當受理)

Form 6675-C CH (06/10)

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。請把我的帳戶從 CARE 計劃中取消。
 ← 如果您將這個圓圈塗黑(●), 請直接填寫第 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.	<input type="checkbox"/> <input type="checkbox"/>	7.	<input type="checkbox"/> <input type="checkbox"/>
2.	<input type="checkbox"/> <input type="checkbox"/>	8.	<input type="checkbox"/> <input type="checkbox"/>
3.	<input type="checkbox"/> <input type="checkbox"/>	9.	<input type="checkbox"/> <input type="checkbox"/>
4.	<input type="checkbox"/> <input type="checkbox"/>	10.	<input type="checkbox"/> <input type="checkbox"/>
5.	<input type="checkbox"/> <input type="checkbox"/>	11.	<input type="checkbox"/> <input type="checkbox"/>
6.	<input type="checkbox"/> <input type="checkbox"/>	12.	<input type="checkbox"/> <input type="checkbox"/>

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

如果多於 \$59,600, 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:

DATE: 06/01/2010



친애하는 고객님:

날짜: 06/01/2010

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.

메디케어(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 Program, NSLP), 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 COMPANYSM 번호로 문의하십시오:

영어: 1-800-427-2200

북경어: 1-800-427-1429

스페인어: 1-800-342-4545

한국어: 1-800-427-0471

광둥어: 1-800-427-1420

월남어: 1-800-427-0478

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



Sempra Energy utility

CARE 20% 요금 할인 확인 양식

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

Form 6675-C KO (06/10)

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 CARE에 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) 귀하 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.	<input type="radio"/> <input type="radio"/>	7.	<input type="radio"/> <input type="radio"/>
2.	<input type="radio"/> <input type="radio"/>	8.	<input type="radio"/> <input type="radio"/>
3.	<input type="radio"/> <input type="radio"/>	9.	<input type="radio"/> <input type="radio"/>
4.	<input type="radio"/> <input type="radio"/>	10.	<input type="radio"/> <input type="radio"/>
5.	<input type="radio"/> <input type="radio"/>	11.	<input type="radio"/> <input type="radio"/>
6.	<input type="radio"/> <input type="radio"/>	12.	<input type="radio"/> <input type="radio"/>

총 연간 가구 소득: 목록 1에 나열된 어느 프로그램에도 참여하지 않으시는 경우, 공제전 귀하 가구의 연간 총 소득 범위에 해당되는 동그라미(●) 안을 채우십시오.

\$0 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

\$59,600 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 \$____,____.00

- (3) *귀하는 본 프로그램 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 Company에 통보하기로 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수도 있다는 것을 본인은 이해합니다. The Gas Company에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에 등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: 날짜: ____ / ____ / ____

SOCALGAS에 한하여서만 사용 :

1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE INC: \$ ____ HH: ____ INITIALS: ____

DATE: 06/01/2010



Kính Gởi Quý Khách Hàng:

Ngày: 06/01/2010

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 gửi 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 gửi 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), Chương trình 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), Bureau of Indian Affairs General Assistance, Food Stamps (SNAP), Chương trình Toàn quốc ăn Trưa tại Trường (NSLP), 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 gửi 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 Cùì 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 Bán Quyền	Mẫu Đơn 1040 IRS, cùng với Liệt Kê E về lợi tức cho thuê
Tiền Lãi 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 cùì 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 COMPANYSM 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

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

Form 6675-C VI (06/10)

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 gửi mẫu đơn này trong phong bì đã trả trả bưu 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.	<input type="radio"/> <input type="radio"/>	7.	<input type="radio"/> <input type="radio"/>
2.	<input type="radio"/> <input type="radio"/>	8.	<input type="radio"/> <input type="radio"/>
3.	<input type="radio"/> <input type="radio"/>	9.	<input type="radio"/> <input type="radio"/>
4.	<input type="radio"/> <input type="radio"/>	10.	<input type="radio"/> <input type="radio"/>
5.	<input type="radio"/> <input type="radio"/>	11.	<input type="radio"/> <input type="radio"/>
6.	<input type="radio"/> <input type="radio"/>	12.	<input type="radio"/> <input type="radio"/>

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Nếu nhiều hơn \$59,600, 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: Ngày: ____ / ____ / ____

PHẦN DÀNH RIÊNG CHO SOCALGAS:

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

INC: \$ _____

HH: ____

INITIALS:

Date: 06/01/2010

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Submetered Residential (Form No. 6677-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



A Sempra Energy utility

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 CompanySM, you will receive the CARE discount from your property owner/manager. You and your property owner/manager will be notified whether or not you are approved for the discount.

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 Program (NSLP), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective June 1, 2010 to May 31, 2011)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Each Additional household member, add	\$7,600

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 - Direct Assistance Program, a low income energy efficiency program, offers free energy-saving home improvements such as ceiling insulation, door weather-stripping, caulking and minor home repair. For more information, please call 1-800-331-7593.

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

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

California Lifeline - 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 (06/10)

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 Program (NSLP)
- 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, 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: _____

Date: _____ / _____ / _____

DATE: 06/01/2010

**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 CompanySM, 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.

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 Healthy Families 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) National School Lunch Program (NSLP) Agencia de Asuntos Indios, Asistencia General (BIA GA) Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal

O

INGRESO MÁXIMO EN EL HOGAR*: <i>(en vigor del 1 de junio de 2010 al 31 de mayo de 2011)</i> *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Por cada miembro adicional en el hogar, añada	\$7,600

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
Coreano: 1-800-427-0471

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

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

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



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

Form 6677-C SP (06/10)

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 complejo
habitacional:

Teléfono: () - -

E-mail:

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
- Healthy Families 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)
- National School Lunch Program (NSLP)
- 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, 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:

Fecha: / /

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Submetered Residential (Form No. 6678-C, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4111
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524



YOUR RATE DISCOUNT IS EXPIRING



Dear Customer:

Date: 06/01/2010

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/manager, 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 Program (NSLP), Low Income Home Energy Assistance Program (LIHEAP), Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME: <i>(effective June 1, 2010 to May 31, 2011)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Each Additional household member, add	\$7,600

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 (06/10)

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):

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 Program (NSLP)
 - 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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

If more than \$59,600, 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: _____ Date: / /

DATE: 06/01/2010



EL DESCUENTO EN SU TARIFA ESTÁ POR VENCER

Apreciable cliente:

Fecha: 06/01/2010

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,



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 Healthy Families 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) National School Lunch Program (NSLP) Agencia de Asuntos Indios, Asistencia General (BIA GA) Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal



INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de junio de 2010 al 31 de mayo de 2011)</i> *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600
Por cada miembro adicional en el hogar, añada	\$7,600

CONDICIONES PARA PARTICIPAR

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

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

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

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

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

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

Número de complejo habitacional (*Facility ID*):



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

Form 6678-C SP (06/10)

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 complejo habitacional:

Teléfono: () - -

E-mail: _____

Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE.
← Si relleno 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) ▼

<input type="radio"/> Medi-Cal / Medicaid: menor de 65 años	<input type="radio"/> Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
<input type="radio"/> Medi-Cal / Medicaid: 65 años o más	<input type="radio"/> Ingreso Suplementario del Seguro Social (SSI)
<input type="radio"/> Healthy Families Categorías A & B	<input type="radio"/> National School Lunch Program (NSLP)
<input type="radio"/> Programa para Mujeres, Infantes, y Niños (WIC)	<input type="radio"/> Agencia de Asuntos Indios, Asistencia General (BIA GA)
<input type="radio"/> Asistencia Temporal para Familias Necesitadas (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal
<input type="radio"/> Cupones para alimentos / SNAP	

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 - \$31,300 \$31,301 - \$36,800 \$36,801 - \$44,400 \$44,401 - \$52,000 \$52,001 - \$59,600

Si es más de \$59,600, escriba el monto aquí : \$ _____ .00 al año

Por favor marque sus fuentes de ingreso: ▼

<input type="radio"/> Seguro Social	<input type="radio"/> Salarios y/o ingresos de autoempleo	<input type="radio"/> Pensión conyugal o alimenticia
<input type="radio"/> SSP o SSDI	<input type="radio"/> Beneficios de desempleo	<input type="radio"/> Becas, subvenciones u otra ayuda usada para sufragar el costo de la vida
<input type="radio"/> Pensiones	<input type="radio"/> Pagos de pólizas de seguro o convenios judiciales	<input type="radio"/> Ingresos por alquiler o regalías
<input type="radio"/> Intereses o dividendos de: cuentas de ahorro, acciones, bonos, o cuentas para el retiro	<input type="radio"/> Pagos por incapacidad o Indemnización para los trabajadores	<input type="radio"/> 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 : ____ / ____ / ____

DATE : 06/01/2010

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM - BILL INSERT
(Form No. 6491-BI, 06/10)

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4111
DECISION NO.

1H6

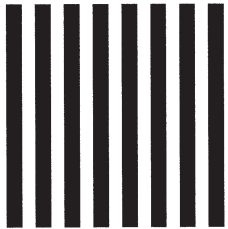
ISSUED BY

Lee Schavrien
Senior Vice President
Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)

DATE FILED May 14, 2010
EFFECTIVE Jun 1, 2010
RESOLUTION NO. E-3524

NO POSTAGE
NECESSARY
IF MAILED
IN THE
UNITED STATES



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

POSTAGE WILL BE PAID BY ADDRESSEE

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



A Sempra Energy utility®

SAVE 20%

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

**VEA SI SU HOGAR CALIFICA. SI SE
ENCUENTRA USTED 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 CompanySM. Please review the program qualifications on the enclosed application to see if you qualify. If you think you qualify, complete the application form and mail it back to us. You will receive your discount once your completed, signed application is approved by The Gas Company. If you have any questions about the CARE program, or need assistance filling out the form, please visit www.socalgas.com/assistance/ or call 1-800-427-2200. Telecommunication Devices for the Speech and Hearing Impaired (TDD) are available at 1-800-252-0259.

ESTIMADO(A) CLIENTE:

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

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

欲知詳情，請洽 免費國語專線: 1-800-427-1429

欲知詳情，請洽 免費粵語專線: 1-800-427-1420

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

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

OTHER PROGRAMS AND SERVICES YOU MAY QUALIFY FOR:

Direct Assistance Program (DAP): 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 Program (NSLP)
- Low Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

2

MAXIMUM HOUSEHOLD INCOME INGRESO MÁXIMO EN EL HOGAR:

(effective June 1, 2010 to May 31, 2011)
(en vigor del 1 de junio de 2010 al 31 de mayo de 2011)

Number of Persons in Household Número de personas en el hogar	Total Annual Income* Ingreso total anual*
1-2	\$31,300
3	\$36,800
4	\$44,400
5	\$52,000
6	\$59,600

←OR/O→

For each additional household member, add \$7,600
Por cada miembro adicional en el hogar, añada \$7,600

*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 Program (NSLP)
 - 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 - \$31,300
 \$31,301 - \$36,800
 \$36,801 - \$44,400
 \$44,401 - \$52,000
 \$52,001 - \$59,600
 If more than \$59,600, enter the dollar amount here/Si es más de \$59,600, 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

3 Declaration / Declaración: Please read and sign below / Por favor lea y firme abajo
I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform The Gas Company if I no longer qualify to receive a discount. I understand that if I receive the discount without qualifying for it, I may be required to pay back the discount I received. I understand that The Gas Company can share my information with other utilities or agents to enroll me in their assistance programs. / Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar prueba de elegibilidad en el programa CARE si se me requiere. Convengo en informar a The Gas Company si dejo de calificar para recibir el descuento. Entiendo que, si recibo el descuento sin tener derecho al mismo, se me puede exigir la devolución del descuento recibido. Entiendo que The Gas Company puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en programas de asistencia.

SIGNATURE/
FIRMA

DATE/
FECHA

No Tape/No use cinta adhesiva

Moisten and Seal/Humedezca y selle

No Staples/No engrape

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GO-AC	Optional Rate for Customers Purchasing New Gas Air Conditioning Equipment (Includes GO-AC and GTO-AC Rates)	46016-G,43154-G 40644-G,40645-G,40646-G
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(TO BE INSERTED BY UTILITY)
 ADVICE LETTER NO. 4111
 DECISION NO.

ISSUED BY
Lee Schavrien
 Senior Vice President
 Regulatory Affairs

(TO BE INSERTED BY CAL. PUC)
 DATE FILED May 14, 2010
 EFFECTIVE Jun 1, 2010
 RESOLUTION NO. E-3524

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