

PUBLIC UTILITIES COMMISSION

505 VAN NESS AVENUE
SAN FRANCISCO, CA 94102-3298



January 2, 2014

Advice Letter No. 4572-G

Rasha Prince
Director Regulatory Affairs
Southern California Gas Company, Sempra Utilities
555 W. Fifth Street, GT14D6
Los Angeles, CA 90013-1011

Subject: Staff's Disposition of Advice Letter No. 4572-G re: revision of CARE Income Eligibility Levels and Application Forms to Comply with Assembly Bill (AB) 327¹.

Dear Ms. Prince:

Advice Letter (AL) 4572-G is approved effective January 1, 2014.

Summary

On November 27, 2013 Southern California Gas Company (SCG) filed AL 4572-G to modify California Alternate Rates for Energy (CARE) income eligibility guidelines in compliance with AB 327 (Perea, 2013). Energy Division staff have reviewed AL 4575-G and the issue raised in the protest by Utility Workers Union of America (UWUA) on December 2, 2013 and the reply filed by SCG on December 20, 2013. The Energy Division finds the advice letter in compliance with AB 327 and thus, rejects UWUA's protest.

Background

On November 27, 2013 SCG filed AL 4572-G to modify CARE income eligibility guidelines in compliance with AB 327 (Perea, 2013). UWUA protested alleging that SCG's CARE application forms fail to notify customers that they may enroll and communicate about the CARE program through in person interactions with Customer Care Representatives (CCRs) as SCG Branch Offices². UWUA suggests adding the following language to each form, after the reference to the telephone number 1-800-427-2200.

"You may also fill out your CARE application form in person and have your questions answered at a SoCalGas Branch Office located near you."

¹ AB327 (Perea, 2013) revises Public Utilities Code Section 739.1 (a) to require that the CARE income eligibility level for one person households to be based on the two person household guideline level effective January 1, 2014.

² Protest of UWUA , p.1

Rasha Prince
September 2, 2014
Page 2

SCG's reply identifies various channels to apply for CARE including; by mail, fax, e-mail, over the phone, online and at local branch offices. Further, SCG claims that it is not efficient or effective to include language only pertaining to one specific channel for CARE applications as suggested in UWUA's protest. SCG's current practice is to establish a single-point of contact for all customers, whether via telephone, in person contact, or other method, in order to accommodate individual situations and customer language preferences³.

Disposition

The Energy Division has completed its review and finds UWUA's protest out of scope. Further, Energy Division agrees with SCG that it is inappropriate to include language only pertaining to one specific channel for CARE applications when other options exist. Energy Division finds AL 4572-G in compliance with AB 327, and thus, rejects UWUA's protest. Advice Letter No. 4572-G is approved effective January 1, 2014.

Sincerely,



Edward Randolph, Director
Energy Division

³ SCG reply, p.3.
431574



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

November 27, 2013

Advice No. 4572

(U 904 G)

Public Utilities Commission of the State of California

Subject: Revision of the CARE Income-Eligibility Guideline Levels and Application Forms to Comply with Assembly Bill (AB) 327

Southern California Gas Company (SoCalGas) hereby submits for filing with the California Public Utilities Commission (Commission) revisions to its Schedule No. G-CARE, California Alternate Rates for Energy (CARE) Program, and the associated tariff forms, applicable throughout its service territory, as shown on Attachment B.

Purpose

The purpose of this filing is to comply with AB 327 which revises Section 739.1 (a) of the Public Utilities (PU) Code to require that the CARE income-eligibility guideline level for one-person households be based on the two-person household guideline level.

Background

The SoCalGas CARE Program provides a 20 percent discount to the utility bill for customers that meet program eligibility requirements.

On March 15, 2012, the Energy Division (ED) issued its annual notice to update the income-eligibility guidelines, effective June 1, 2012 - May 31, 2013, in compliance with Section 739.1 (b) (1) of the PU Code. The notice also declared that "income limits for households with 1-2 persons are now correctly listed separately and will no longer be consolidated." On May 14, 2012, SoCalGas filed Advice No. (AL) 4369 to comply with the notice, providing separate eligibility guidelines for households with 1 or 2 members, with the annual income thresholds associated with each household size.

SoCalGas most recently adjusted its CARE and ESA Programs' income-eligibility levels pursuant to updated income guidelines from the ED to be effective from June 1, 2013 through

May 31, 2014.¹ The notification letter, which continued to list 1 and 2 member households separately, directed the energy utilities to file revised tariffs with the ED reflecting the new income levels by May 14, 2013. SoCalGas submitted Advice Letter 4492 on that date and received approval on June 4, 2013. These represent the currently effective CARE eligibility guidelines and associated forms.

On October 7, 2013, AB 327 was approved by the Governor, in part, amending Section 739.1 of the PU Code. AB 327 becomes effective January 1, 2014 and specifically revises PU Code Section 739.1 (a) as follows:

For one-person households, program eligibility shall be based on two-person household guideline levels.²

In order to comply with AB 327 by its effective date, SoCalGas provides the necessary revisions to its CARE Program eligibility requirements and forms, such that the income-eligibility guidelines for one-person households will henceforth be based on two-person household guideline levels.

Tariff Revisions

Pursuant to the revised Section 739.1 (a), SoCalGas submits the updated Schedule No. G-CARE and CARE application instructions and forms. This filing includes nine 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; sub-metered bilingual self-certification; sub-metered bilingual self-recertification; and bilingual bill insert.

Protest

Anyone may protest this AL to the 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 AL, which is December 17, 2013. 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

A copy of the protest should also be sent via e-mail to the attention of the ED Tariff Unit (EDTariffUnit@cpuc.ca.gov). 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.

¹ Pursuant to a letter dated April 1, 2013 from the Director of the ED.

² See Assembly Bill 327, Section 3,

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140AB327.

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 ED disposition and should be classified as Tier 1 (effective pending disposition) pursuant to GO 96-B. The tariffs filed herein are to become effective January 1, 2014.

Notice

A copy of this advice letter is being sent to the parties listed on Attachment A, which includes the service lists for A.11-05-018 and 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) #: 4572

Subject of AL: Revision of the CARE Income-Eligibility Guideline Levels and Application Forms to Comply with Assembly Bill (AB) 327

Keywords (choose from CPUC listing): CARE; Forms

AL filing type: Monthly Quarterly Annual One-Time Other

If 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: 1/1/14

No. of tariff sheets: 14

Estimated system annual revenue effect (%): N/A

Estimated system average rate effect (%): N/A

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: G-CARE, 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
EDTariffUnit@cpuc.ca.gov**

**Southern California Gas Company
Attention: Sid Newsom
555 West Fifth Street, GT14D6
Los Angeles, CA 90013-1011
snewsom@semprautilities.com
Tariffs@socalgas.com**

¹ Discuss in AL if more space is needed.

ATTACHMENT A

Advice No. 4572

(See Attached Service List)

ATTACHMENT B
Advice No. 4572

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 49797-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 2	Revised 49144-G
Revised 49798-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 4	Revised 48176-G*
Revised 49799-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY (CARE) PROGRAM FOR QUALIFIED , AGRICULTURAL EMPLOYEE HOUSING (Form 6632-C, 01/14)	Revised 49145-G
Revised 49800-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM FOR QUALIFIED NONPROFIT, GROUP LIVING FACILITIES (Form 6571-D, 01/14)	Revised 49146-G
Revised 49801-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - GENERAL PURPOSE, DIRECT MAIL (Form 6491-DM, 01/14)	Revised 49147-G
Revised 49802-G	SAMPLE FORMS: APPLICATIONS, Self- Certification CARE Application, Individually Metered Residential (Form 6491-D, 01/14)	Revised 49148-G
Revised 49803-G	SAMPLE FORMS: APPLICATIONS, Self- Recertification CARE Application, Individually Metered Residential (Form 6674-D, 01/14)	Revised 49149-G
Revised 49804-G	SAMPLE FORMS: APPLICATIONS, Capitation Program CARE Application, (Form 6491-2D, 01/14)	Revised 49150-G
Revised 49805-G	SAMPLE FORMS: APPLICATIONS, Self- Certification CARE Application, Submetered Residential (Form 6677-D, 01/14)	Revised 49153-G
Revised 49806-G	SAMPLE FORMS: APPLICATIONS, Self- Recertification CARE Application, Submetered Residential (Form 6678-D, 01/14)	Revised 49154-G
Revised 49807-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - BILL INSERT, (Form 6491-BI, 01/14)	Revised 49155-G

ATTACHMENT B
Advice No. 4572

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 49808-G	TABLE OF CONTENTS	Revised 49696-G
Revised 49809-G	TABLE OF CONTENTS	Revised 49157-G
Revised 49810-G	TABLE OF CONTENTS	Revised 49757-G

Schedule No. G-CARE

Sheet 2

CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM

(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	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260

For households with more than six persons, add \$8,040 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.

(Continued)

(TO BE INSERTED BY UTILITY)
 ADVICE LETTER NO. 4572
 DECISION NO.

ISSUED BY
Lee Schavrien
 Senior Vice President

(TO BE INSERTED BY CAL. PUC)
 DATE FILED Nov 27, 2013
 EFFECTIVE Jan 1, 2014
 RESOLUTION NO. _____

Schedule No. G-CARE

Sheet 4

CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM

(Continued)

SPECIAL CONDITIONS (Continued)

NON-PROFIT GROUP LIVING FACILITY CUSTOMERS

13. Eligibility Criteria: In order for the customer to be eligible for the CARE discount, and to be considered a qualified non-profit group living facility, each of the following provisions must be met:

a. The facility must certify that it is one of the following: a homeless shelter, women's shelter, transitional housing, a short- or long-term care facility, or a group home for physically or mentally disabled persons.

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 \$31,020.

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. 4572
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)
DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY (CARE) PROGRAM FOR QUALIFIED
AGRICULTURAL EMPLOYEE HOUSING (Form 6632-C, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H10

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



APPLICATION FOR 20% DISCOUNT California Alternate Rates for Energy (CARE) Program For Qualified Agricultural Employee Housing Facilities

A Sempra Energy utility®

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:** Southern California Gas Company (SoCalGas®)
CARE Program - ML 19A1
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.

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
<p>If another person in the household participates in any of these programs:</p> <ul style="list-style-type: none"> Medicaid or Medi-Cal Healthy Families A&B Women, Infants, & Children (WIC) CalWORKs (TANF) or Tribal TANF Head Start Income Eligible - Tribal Only Bureau of Indian Affairs General Assistance CalFresh / SNAP (Food Stamps) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:	
<i>(effective January 1, 2014 to May 31, 2014)</i>	
<small>*current household income from all sources before deductions</small>	
Number of Persons in Household	Total Annual Income
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each Additional Person	+\$8,040

- 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 SoCalGas'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-D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H10

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____

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 SOUTHERN CALIFORNIA GAS COMPANY (SoCalGas®) 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: CARE PROGRAM
SoCalGas
PO BOX 515005 ML GT19A1
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 every 2 years. 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	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:
SoCalGas
CARE Program, ML
GT19A1 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 SoCalGas 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 SoCalGas 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



**CARE QUALIFICATIONS
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 6571 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:

PUBLIC ASSISTANCE PROGRAMS:

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

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

OR

MAXIMUM HOUSEHOLD INCOME*:

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

Number of Persons	Total Yearly Individual Resident’s Income In Facility Cannot Be More Than*
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each Additional Person	+ \$8,040
	<i>*(effective January 1, 2014 to May 31, 2014)</i>

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 6491-DM, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H10

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



Southern California Gas Company



CARE 20 PERCENT DISCOUNT

Dear Customer,

Through our California Alternate Rates for Energy (CARE) program, Southern California Gas Company (SoCalGas®) offers a 20 percent 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 socialgas.com (search "CARE").

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

HOW TO QUALIFY

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)
- CalWORKs (TANF) or Tribal TANF
- Head Start Income Eligible – Tribal Only
- Bureau of Indian Affairs General Assistance (BIA GA)
- CalFresh/SNAP (Food Stamps)
- National School Lunch Program (NSLP)
- Low-Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

←OR→

MAXIMUM HOUSEHOLD INCOME:

(effective January 1, 2014 to May 31, 2014)

Number of Persons in Household	Total Annual Income*
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260

For each additional household member, add \$8,040

* 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 SoCalGas within 30 days if you no longer qualify.
- 5) You may be asked to verify your eligibility for CARE.

SoCalGas 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 socialgas.com (search "ASSISTANCE") or call 1-800-427-2200.

Sincerely,
Ted Humphrey
CARE Program Sr. Market Advisor



CARE APPLICATION

For a 20 Percent Discount

To qualify for the 20 percent discount, please complete the application form and return it to Southern California Gas Company (SoCalGas®). You will receive your discount once your completed, signed application is approved by SoCalGas.

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

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

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

If more than \$55,140, enter the dollar amount here: \$, .00 per year

Please mark your sources of income:

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

SOUTHERN CALIFORNIA GAS COMPANY CARE PROGRAM
M.L. GT19A1, PO Box 515005, Los Angeles CA 90099-9316

Southern California Gas Company - Source Code



Southern
California
Gas Company



CARE 20 POR CIENTO DE DESCUENTO

Estimado Cliente:

Por medio de nuestro programa Tarifas Alternas para Energía de California (CARE), Southern California Gas Company (SoCalGas®) ofrece un 20 por ciento 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 recientemente desempleado, usted ahora puede tener derecho al programa CARE. Si usted cree 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 socialgas.com/espanol (busque la palabra clave "CARE").

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

COMO PUEDE CALIFICAR

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)
CalWORKs (TANF) o TANF tribal
Elegible para ingreso de Ventaja Inicial - Solamente tribal
Agencia de Asuntos Indios, Asistencia General (BIA GA)
CalFresh/SNAP (Food Stamps/Estampillas para comida)
National School Lunch Program (NSLP)
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)



INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de enero de 2014 al 31 de mayo de 2014)

Número de personas en el hogar	Ingreso total anual*
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260

Por cada miembro adicional en el hogar, añada \$8,040

* Incluye los ingresos actuales del hogar de todas las fuentes de ingreso antes de deducciones.

CONDICIONES PARA PARTICIPAR

1) La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal. 2) No puede aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge. 3) Debe volver a acreditar su elegibilidad para CARE siempre que se lo soliciten. 4) Debe notificar a SoCalGas dentro de un plazo de 30 días si deja ser apto para el programa. 5) Puede solicitársele que verifique su elegibilidad para CARE.

SoCalGas se compromete a crear maneras de ayudar a nuestros clientes manejar su consumo de energía y ahorrar dinero. Si tiene preguntas o quisiera más información acerca de nuestros programas de asistencia, por favor visite socialgas.com/espanol (busque la palabra clave "ASISTENCIA") o llámenos al 1-800-342-4545.

Atentamente,
Ted Humphrey
Gerente del programa CARE



SOLICITUD CARE PARA UN 20 Por Ciento de Descuento

A Sempra Energy utility®

Para tener derecho al 20 por ciento de descuento, por favor llene el formulario de solicitud y regréselo a Southern California Gas Company (SoCalGas®). Recibirá su descuento una vez que su solicitud llena y firmada sea aprobada por SoCalGas.

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)

- 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)
- CalWORKs (TANF) o TANF Tribal
- CalFresh/SNAP (Estampillas para comida)

- 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

¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)?

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Si es más de \$55,140, escriba la suma anual: \$, .00

Por favor marque sus fuentes de ingreso:

- | | | |
|---|---|--|
| <input type="radio"/> Seguro Social | <input type="radio"/> Salarios y/o ingresos de autoempleo | <input type="radio"/> Pension 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

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 SoCalGas 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 SoCalGas puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia.

FIRMA:

FECHA: / /

Envíe ésta solicitud por correo en el sobre con timbre pagado por adelantado a:

SOUTHERN CALIFORNIA GAS COMPANY CARE PROGRAM
M.L. GT19A1, PO Box 515005, Los Angeles CA 90099-9316

Southern California Gas Company - Source Code

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Individually Metered Residential (Form 6491-D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H12

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



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 and return the application by mail, fax, or apply online at socialgas.com (Search "CARE")

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or someone in your household participates in any of these programs:
<ul style="list-style-type: none"> Medicaid or Medi-Cal Healthy Families A&B Women, Infants, & Children (WIC) CalWORKs (TANF) or Tribal TANF Head Start Income Eligible - Tribal Only Bureau of Indian Affairs General Assistance CalFresh / SNAP (Food Stamps) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective January 1, 2014 to May 31, 2014)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each Additional Person	+\$8,040

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:

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



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

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

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

FOR MORE INFORMATION ON CUSTOMER ASSISTANCE:

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

Hearing Impaired (TDD/TTY): 1-800-252-0259 (available in English and Spanish only)
FAX: (213) 244-4665



CARE 20% Rate Discount Application

Form 6491-D EN (01/14)

Please use DARK ink and print clearly to ensure proper processing

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Correct way to mark circles: ●



1	Customer Name (as it appears on your bill):	
	Home Address (street, city, zip):	
	Account Number:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Phone Number:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	E-mail:	<input type="text"/>

2	Total # of adults and children in your household:	<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"/> If more than 6: <input type="text"/>											
	Are you (or someone in your household) enrolled in any of the following assistance programs?												
	<input type="radio"/> YES (If yes, mark the program(s) of participation) ▼ <table border="0"> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: Under Age 65</td> <td><input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)</td> </tr> <tr> <td><input type="radio"/> Medi-Cal / Medicaid: 65 or older</td> <td><input type="radio"/> Supplemental Security Income (SSI)</td> </tr> <tr> <td><input type="radio"/> Healthy Families Categories A & B</td> <td><input type="radio"/> National School Lunch Program (NSLP)</td> </tr> <tr> <td><input type="radio"/> Women, Infants, and Children Program (WIC)</td> <td><input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA)</td> </tr> <tr> <td><input type="radio"/> CalWORKs (TANF) or Tribal TANF</td> <td><input type="radio"/> Head Start Income Eligible - Tribal Only</td> </tr> <tr> <td><input type="radio"/> CalFresh / SNAP (Food Stamps)</td> <td></td> </tr> </table>		<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"/> CalWORKs (TANF) or Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Only	<input type="radio"/> CalFresh / SNAP (Food Stamps)
<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"/> CalWORKs (TANF) or Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Only												
<input type="radio"/> CalFresh / SNAP (Food Stamps)													
<input type="radio"/> NO		What is your yearly household income (before deductions, including all members of the household)? ▼											
		<input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140											
		<input type="radio"/> If more than \$55,140, enter amount here: \$ <input type="text"/> , <input type="text"/> .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: <input checked="" type="text"/> _____ Date: <input type="text"/> / <input type="text"/> / <input type="text"/>



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.

Por favor, complete y envíe la solicitud por correo, fax, o visite socialgas.com/español (busque la palabra clave "CARE").

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)
CalWORKs (TANF) o TANF Tribal
CalFresh / SNAP (Estampillas para Comida)
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 enero de 2014 al 31 de mayo de 2014) *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Cada personal adicional	+\$8,040

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:

Energy Savings Assistance Program: 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)

Fax: (213)244-4665



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

Form 6491-D SP (01/14)

CARE PROGRAM, ML GT19A1 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:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Teléfono:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Correo electrónico:	<input type="text"/>

2	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>¿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) ▼</p> <table style="width: 100%;"> <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"/> CalWORKs (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"/> CalFresh / SNAP (Estampillas para Comida)</td> <td></td> </tr> </table> <p><input type="radio"/> No</p> <p>¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼</p> <p> <input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140 </p> <p><input type="radio"/> Si es más de \$55,140, escriba el monto aquí : \$ <input type="text"/>, <input type="text"/>.00 al año</p> <p>Por favor marque sus fuentes de ingreso: ▼</p> <table style="width: 100%;"> <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"/> CalWORKs (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal	<input type="radio"/> CalFresh / SNAP (Estampillas para Comida)		<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
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<input type="radio"/> Pensiones	<input type="radio"/> Pagos de pólizas de seguro o convenios judiciales	<input type="radio"/> Ingresos por alquiler o regalías																						
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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"/> <input type="text"/></p> <p>Fecha : <input type="text"/> / <input type="text"/> / <input type="text"/></p>

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 折扣的這些種資格:

政府協助計劃:	或者	家庭收入最高限額*: (有效期 2014 年 1 月 1 日至 2014 年 5 月 31 日) *包括所有來源的家庭現有稅前收入	
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)、CalWORKs (TANF)、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)、CalFresh / SNAP (食物券)、National School Lunch Program (NSLP, 全國學童免費午餐計劃)、Low Income Home Energy Assistance Program (LIHEAP, 低收入家庭能源協助計劃)、Supplemental Security Income (SSI, 社會安全補助金)	或者	家庭成員人數	年收入總額
		1	\$31,020
		2	\$31,020
		3	\$39,060
		4	\$47,100
		5	\$55,140
		6	\$63,180
		7	\$71,220
		8	\$79,260
		多一位家庭成員	+\$8,040

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:

Energy Savings Assistance Program: 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)

FAX: (213) 244-4665



A Sempra Energy utility®

CARE 20% 費率折扣申請表

Form 6491-D CH (01/14)

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: ●

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1	客戶姓名:	
	地址:	
	帳戶號碼:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	聯絡電話:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	電郵地址:	<input type="text"/>

2	<p>您家庭中的總人數: <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"/> 如果超過 6: <input type="text"/></p>																							
	<p>您 (或您的家人) 是否有人參加了以下協助計劃?</p> <p><input type="radio"/> 是 (請把您或您家人所接受福利的計劃前塗黑) ▼</p> <table border="0"> <tr> <td><input type="radio"/> 加州醫療輔助計劃: 低於 65 歲</td> <td><input type="radio"/> LIHEAP 低收入家庭能源協助計劃</td> </tr> <tr> <td><input type="radio"/> 加州醫療輔助計劃: 65 歲或更大年齡</td> <td><input type="radio"/> 社會安全輔助金 (SSI)</td> </tr> <tr> <td><input type="radio"/> 健康家庭低費兒童醫療健保計劃類別 A 及 B</td> <td><input type="radio"/> 全國學童午餐計劃 (NSLP)</td> </tr> <tr> <td><input type="radio"/> WIC - 婦女, 嬰兒和兒童營養輔助計劃</td> <td><input type="radio"/> 印第安事務局一般援助</td> </tr> <tr> <td><input type="radio"/> CalWORKs (TANF) 或 部落 TANF</td> <td><input type="radio"/> 學前教育班補助金計劃 (僅限於部落)</td> </tr> <tr> <td><input type="radio"/> CalFresh / SNAP (食物券)</td> <td></td> </tr> </table> <p><input type="radio"/> 否</p> <p>請按照您的家庭年收入 (稅前收入, 包括所有家庭成員), 把適當項目的圓圈塗黑: ▼</p> <p><input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140</p> <p><input type="radio"/> 如果多於 \$54,140, 請在此處填寫金額: \$ <input type="text"/><input type="text"/><input type="text"/><input type="text"/>.00 每年</p> <p>請把您家庭收入所有來源前面的圓圈塗黑: ▼</p> <table border="0"> <tr> <td><input type="radio"/> 社會安全福利金 Social Security</td> <td><input type="radio"/> 工資或薪金</td> <td><input type="radio"/> 配偶或子女支付的贍養費</td> </tr> <tr> <td><input type="radio"/> 社會安全輔助金 SSP, SSDI</td> <td><input type="radio"/> 失業救濟金</td> <td><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</td> </tr> <tr> <td><input type="radio"/> 退休金</td> <td><input type="radio"/> 保險或法律賠償</td> <td><input type="radio"/> 租金或權利金收入</td> </tr> <tr> <td><input type="radio"/> 從以下項目獲取的利息或紅利: 儲蓄賬戶, 股票, 債券, 或退休賬戶</td> <td><input type="radio"/> 殘疾津貼或勞工補償</td> <td><input type="radio"/> 現金或其它收入</td> </tr> </table>	<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"/> CalWORKs (TANF) 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"/> CalFresh / SNAP (食物券)		<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: 儲蓄賬戶, 股票, 債券, 或退休賬戶	<input type="radio"/> 殘疾津貼或勞工補償
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<input type="radio"/> CalWORKs (TANF) 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"/> CalFresh / SNAP (食物券)																								
<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: 儲蓄賬戶, 股票, 債券, 或退休賬戶	<input type="radio"/> 殘疾津貼或勞工補償	<input type="radio"/> 現金或其它收入																						

3	<p>您同意以下聲明嗎? 請您閱讀並簽字。</p> <p>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。</p>
	<p>簽名: <input checked="" type="text"/> 日期: <input type="text"/> / <input type="text"/> / <input type="text"/></p>



캘리포니아 에너지 대체 요금 신청서

The Gas Company의 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 가지 방법이 있습니다:

공공 지원 프로그램:
<p>귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우:</p> <ul style="list-style-type: none"> 메디케이드 (Medicaid / Medi-Cal), 건강한 가족 유형 A 및 B (Healthy Families A&B), 여성, 유아 및 어린이 (WIC), CalWORKs (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), CalFresh / SNAP (푸드 스탬프), 학교 점심 프로그램 (National School Lunch Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)

또는

최대 가구 소득*: (2014. 1. 1 부터 2014. 5. 31 까지 유효) *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
각 추가 사용자	+\$8,040

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:

Energy Savings Assistance Program – 천장 단열, 문 통풍 마개 처리, 코킹 및 경미한 주택 수리와 같은 에너지 절약 주택 개량공사를 무료로 제공합니다.



자세한 내용은 1-800-427-0471 번으로 문의하십시오.

Medical Baseline (의료 저율요금) – 특정한 의학적 상태에 처한 고객들에게 저렴한 요금으로 추가 할당량의 가스를 제공합니다. 자세한 내용은 1-800-427-0471 번으로 문의하십시오.

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

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

고객 지원에 대한 추가 사항은 다음 번호로 문의하십시오:

- 영어: 1-800-427-2200 북경어: 1-800-427-1429 스페인어: 1-800-342-4545
- 한국어: 1-800-427-0471 광둥어: 1-800-427-1420 월남어: 1-800-427-0478
- 청각 장애자(TDD/TTY): 1-800-252-0259 (영어와 스페인어로 만 유효함)
- Fax: (213) 244-4665



CARE 20% 요금 할인 신청서

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

Form 6491-D KO (01/14)

CARE PROGRAM ML GT19A1
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 질문으로 가십시오.)▼

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

○ 아니오

귀하의 연간 소득은 얼마입니까 (공제전, 모든 가족의 소득 포함)?

○ \$0 - \$22,980 ○ \$22,981 - \$31,020 ○ \$31,021 - \$39,060 ○ \$39,061 - \$47,100 ○ \$47,101 - \$55,140

○ \$55,140 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간\$, , .00

귀하의 소득원에 표시하십시오: ▼

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

3

다음 사항에 동의하십니까? 아래 사항을 읽고 서명하십시오.

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

서명:

날짜: / /

**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), CalWORKs (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, CalFresh / SNAP (Trợ Cấp Phiếu Thực Phẩm), 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

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH*: (hiệu lực từ ngày 1 tháng Một, 2014 đến 31 tháng Năm, 2014) *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	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Mỗi người bổ sung	+\$8,040

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:

Energy Savings 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)

Fax: (213) 244-4665



A Sempra Energy utility®

Đơn Xin Giảm Giá 20% Theo Chương Trình CARE

Form 6491-D VI (01/14)

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

CARE PROGRAM ML GT19A1

PO BOX 3249

LOS ANGELES, CA 90051-1249

Bôi đen đúng cách: ●

1	Tên Khách Hàng:	
	Địa chỉ:	
	Số Trương Mục:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Điện Thoại Nhà #:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	E-mail:	<input type="text"/>

2	<p>Tổng số người trong hộ gia đình của quý vị: <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"/> nếu có nhiều hơn 6: <input type="text"/></p>																							
	<p>Quý vị (hoặc ai đó trong gia đình quý vị) có được hưởng bất cứ chương trình trợ giúp nào sau đây không?</p> <p><input type="radio"/> CÓ (Nếu có, xin bôi đen vào vòng tròn của (các) chương trình được hưởng) ▼</p> <table border="0"> <tr> <td><input type="radio"/> Medi-Cal/Medicaid: Dưới 65 tuổi</td> <td><input type="radio"/> Trợ Giúp Năng Lượng Tại Gia Cho Người Lợi Tức Thấp (LIHEAP)</td> </tr> <tr> <td><input type="radio"/> Medi-Cal/Medicaid: 65 tuổi hoặc hơn</td> <td><input type="radio"/> Trợ Cấp An Sinh (SSI)</td> </tr> <tr> <td><input type="radio"/> Gia Đình Khỏe Mạnh Loại A & B</td> <td><input type="radio"/> Chương Trình Toàn Quốc Ăn Trưa Tại Trường (NSLP)</td> </tr> <tr> <td><input type="radio"/> Chương Trình Phụ Nữ Sơ Sinh và Trẻ Em (WIC)</td> <td><input type="radio"/> Bureau of Indian Affairs General Assistance</td> </tr> <tr> <td><input type="radio"/> CalWORKs (TANF) hoặc TANF Bản Địa</td> <td><input type="radio"/> Đủ điều kiện lợi tức cho Head Start (Bản Địa mà thôi)</td> </tr> <tr> <td><input type="radio"/> CalFresh / SNAP (Trợ Cấp Phiếu Thực Phẩm)</td> <td></td> </tr> </table> <p><input type="radio"/> KHÔNG</p> <p>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)? ▼</p> <p><input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140</p> <p><input type="radio"/> Nếu nhiều hơn \$55,140, xin điền tổng số vào đây \$ <input type="text"/>, <input type="text"/>.00 mỗi năm</p> <p>Xin bôi đen vào vòng tròn của các nguồn lợi tức của quý vị: ▼</p> <table border="0"> <tr> <td><input type="radio"/> An sinh Xã hội</td> <td><input type="radio"/> Lương và/hoặc Lợi tức Việc Làm Tự do</td> <td><input type="radio"/> Cấp dưỡng nuôi Con hoặc Phôi ngẫu</td> </tr> <tr> <td><input type="radio"/> SSP, SSDI</td> <td><input type="radio"/> Trợ cấp Thất nghiệp</td> <td><input type="radio"/> Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống</td> </tr> <tr> <td><input type="radio"/> Hưu bổng</td> <td><input type="radio"/> Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định</td> <td><input type="radio"/> Lợi tức cho Thuê hoặc Tiền Bản quyền</td> </tr> <tr> <td><input type="radio"/> Tiền Lãi hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí</td> <td><input type="radio"/> Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm</td> <td><input type="radio"/> Lợi tức Tiền mặt hoặc Lợi tức Khác</td> </tr> </table>	<input type="radio"/> Medi-Cal/Medicaid: Dưới 65 tuổi	<input type="radio"/> Trợ Giúp Năng Lượng Tại Gia Cho Người Lợi Tức Thấp (LIHEAP)	<input type="radio"/> Medi-Cal/Medicaid: 65 tuổi hoặc hơn	<input type="radio"/> Trợ Cấp An Sinh (SSI)	<input type="radio"/> Gia Đình Khỏe Mạnh Loại A & B	<input type="radio"/> Chương Trình Toàn Quốc Ăn Trưa Tại Trường (NSLP)	<input type="radio"/> Chương Trình Phụ Nữ Sơ Sinh và Trẻ Em (WIC)	<input type="radio"/> Bureau of Indian Affairs General Assistance	<input type="radio"/> CalWORKs (TANF) hoặc TANF Bản Địa	<input type="radio"/> Đủ điều kiện lợi tức cho Head Start (Bản Địa mà thôi)	<input type="radio"/> CalFresh / SNAP (Trợ Cấp Phiếu Thực Phẩm)		<input type="radio"/> An sinh Xã hội	<input type="radio"/> Lương và/hoặc Lợi tức Việc Làm Tự do	<input type="radio"/> Cấp dưỡng nuôi Con hoặc Phôi ngẫu	<input type="radio"/> SSP, SSDI	<input type="radio"/> Trợ cấp Thất nghiệp	<input type="radio"/> Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống	<input type="radio"/> Hưu bổng	<input type="radio"/> Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định	<input type="radio"/> Lợi tức cho Thuê hoặc Tiền Bản quyền	<input type="radio"/> Tiền Lãi hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí	<input type="radio"/> Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm
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3	<p>Quý vị có đồng ý với điều sau đây không? Xin đọc và ký bên dưới.</p> <p>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</p> <p>Chữ ký: X Ngày: <input type="text"/> / <input type="text"/> / <input type="text"/></p>																							

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

يرجى استيفاء الطلب وإعادته أو التقدم بطلب على الإنترنت من خلال الموقع socialgas.com (ابحث عن "CARE")

كيف تتأهل للحصول على تخفيض CARE

الحد الأعلى لدخل العائلة*:		أو	برامج المساعدة الحكومية:
(ساري المفعول من 1 يناير 2014 إلى 31 مايو 2014) * دخل العائلة الجاري من جميع المصادر قبل الحسم			إذا كنت أنت أو أي من أفراد أسرتك تتلقون معونات من أي من البرامج التالية:
الدخل السنوي الإجمالي	عدد أفراد العائلة		Medi-Cal أو Medicaid
31,020 دولار أمريكي	1		Healthy Families A&B
31,020 دولار أمريكي	2		Women, Infants, & Children (WIC)
39,060 دولار أمريكي	3		CalWORKs (TANF) أو Tribal TANF
47,100 دولار أمريكي	4		Head Start Income Eligible - Tribal Only
55,140 دولار أمريكي	5		Bureau of Indian Affairs General Assistance
63,180 دولار أمريكي	6		CalFresh / SNAP (Food Stamps)
71,220 دولار أمريكي	7		National School Lunch Program (NSLP)
79,260 دولار أمريكي	8		Low Income Home Energy Assistance Program
8,040 دولار أمريكي+	لكل فرد إضافي في العائلة أضف		Supplemental Security Income (SSI)

شروط الاشتراك

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

قد تتأهل لبرامج أو خدمات أخرى:

Energy Savings Assistance Program

Energy Savings Assistance Program: يقدم تحسينات منزلية مجانية لتوفير الطاقة مثل عزل السقف، والأشربة والمعاجين الخاصة بمقاومة العوامل الجوية للأبواب والنوافذ، والترميمات المنزلية الصغيرة لمالك المنازل والمستأجرين المؤهلين ذوي الدخل المحدود. لمزيد من المعلومات، يرجى الاتصال بالرقم 1-800-331-7593.

Medical Baseline – يوفر حصة إضافية من الغاز بسعر أرخص للعملاء ذو الاحتياجات الطبية الخاصة. لمزيد من المعلومات، اتصل بالرقم 1-800-427-2200.

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

California Lifeline – خدمة هاتفية مخفضة للعملاء الذين يحققون مستويات دخل مماثلة لـ CARE. لمزيد من المعلومات، اتصل بالشركة المزودة للخدمات الهاتفية لمنطقتك.

للمزيد من المعلومات حول مساعدة المشترك:

1-888-427-1345

تتوفر المعلومات لمن يشكو من إعاقة سمعية بالرقم التالي: 1-800-252-0259 (باللغتين الإنجليزية والأسبانية فقط)
فاكس: (213)244-4665

طلب تخفيض 20% خاص ببرنامج CARE

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

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	<p>اسم المشترك (كما يظهر على الفاتورة):</p> <p>العنوان (اسم الشارع والمدينة والرمز البريدي):</p> <p>رقم الحساب</p> <p>رقم الهاتف</p> <p>البريد الإلكتروني</p>	1
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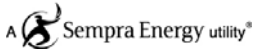
	<p>عدد أفراد العائلة البالغين : <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 6+ : <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/></p> <p>هل تشارك أنت (أو شخص آخر في عائلتك) في أي واحد من البرامج التالية؟</p> <p><input type="radio"/> نعم (إذا أجبت بنعم، ضع علامة أمام البرنامج أو البرامج التي تشارك فيها) ▼</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="radio"/> Medi-Cal / Medicaid: أقل من 65 سنة <input type="radio"/> Medi-Cal / Medicaid: 65 سنة أو أكثر <input type="radio"/> Healthy Families Categories A & B <input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Tribal TANF أو CalWORKs (TANF) <input type="radio"/> CalFresh / SNAP (Food Stamps) </td> <td style="width: 50%; border: 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 – قبلي فقط </td> </tr> </table> <p><input type="radio"/> لا</p> <p>ما هو دخل العائلة السنوي (قبل الخصومات، بما فيه جميع أفراد العائلة)؟ ▼</p> <p>0 – 22,980 دولار <input type="radio"/> 22,981 – 31,020 دولار <input type="radio"/> 31,021 – 39,060 دولار <input type="radio"/> 39,061 – 47,100 دولار <input type="radio"/> 47,101 – 55,140 دولار <input type="radio"/> 55,140 دولار أو أكثر <input type="radio"/></p> <p>إذا زاد عن الدخل عن 55,140 دولار ضع الرقم هنا: 00. <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/></p> <p>الرجاء وضع علامة أمام مصدر أو مصادر دخلك: ▼</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="radio"/> Social Security <input type="radio"/> SSDI أو SSP <input type="radio"/> معاش <input type="radio"/> فوائد أو أرباح من: <input type="radio"/> حسابات ادخار أو أسهم أو <input type="radio"/> سندات أو حسابات تقاعد </td> <td style="width: 33%; border: none;"> <input type="radio"/> المرتبات والأجور و/أو أرباح من عمل حر <input type="radio"/> تعويضات العاطلين عن العمل <input type="radio"/> تسويات قانونية أو تأمين <input type="radio"/> تعويضات عجز (إعاقة) أو تعويضات العاملين </td> <td style="width: 33%; border: none;"> <input type="radio"/> نفقة زوجية أو نفقة طفل <input type="radio"/> منح أو منح مدرسية أو منح أخرى تُستعمل لنفقات العيش <input type="radio"/> إيجار أو علاوات <input type="radio"/> نقد أو مصدر دخل آخر </td> </tr> </table>	<input type="radio"/> Medi-Cal / Medicaid: أقل من 65 سنة <input type="radio"/> Medi-Cal / Medicaid: 65 سنة أو أكثر <input type="radio"/> Healthy Families Categories A & B <input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Tribal TANF أو CalWORKs (TANF) <input type="radio"/> CalFresh / SNAP (Food Stamps)	<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 – قبلي فقط	<input type="radio"/> Social Security <input type="radio"/> SSDI أو SSP <input type="radio"/> معاش <input type="radio"/> فوائد أو أرباح من: <input type="radio"/> حسابات ادخار أو أسهم أو <input type="radio"/> سندات أو حسابات تقاعد	<input type="radio"/> المرتبات والأجور و/أو أرباح من عمل حر <input type="radio"/> تعويضات العاطلين عن العمل <input type="radio"/> تسويات قانونية أو تأمين <input type="radio"/> تعويضات عجز (إعاقة) أو تعويضات العاملين	<input type="radio"/> نفقة زوجية أو نفقة طفل <input type="radio"/> منح أو منح مدرسية أو منح أخرى تُستعمل لنفقات العيش <input type="radio"/> إيجار أو علاوات <input type="radio"/> نقد أو مصدر دخل آخر	2
<input type="radio"/> Medi-Cal / Medicaid: أقل من 65 سنة <input type="radio"/> Medi-Cal / Medicaid: 65 سنة أو أكثر <input type="radio"/> Healthy Families Categories A & B <input type="radio"/> Women, Infants, and Children Program (WIC) <input type="radio"/> Tribal TANF أو CalWORKs (TANF) <input type="radio"/> CalFresh / SNAP (Food Stamps)	<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 – قبلي فقط						
<input type="radio"/> Social Security <input type="radio"/> SSDI أو SSP <input type="radio"/> معاش <input type="radio"/> فوائد أو أرباح من: <input type="radio"/> حسابات ادخار أو أسهم أو <input type="radio"/> سندات أو حسابات تقاعد	<input type="radio"/> المرتبات والأجور و/أو أرباح من عمل حر <input type="radio"/> تعويضات العاطلين عن العمل <input type="radio"/> تسويات قانونية أو تأمين <input type="radio"/> تعويضات عجز (إعاقة) أو تعويضات العاملين	<input type="radio"/> نفقة زوجية أو نفقة طفل <input type="radio"/> منح أو منح مدرسية أو منح أخرى تُستعمل لنفقات العيش <input type="radio"/> إيجار أو علاوات <input type="radio"/> نقد أو مصدر دخل آخر					

<p>هل توافق على ما يلي؟ الرجاء القراءة والتوقيع أدناه.</p> <p>أصرح بأن المعلومات التي أوردتها في هذا الطلب هي صحيحة وحقيقية. وأوافق على تقديم إثباتات على أهليتي لبرنامج CARE في حال طلب مني. أما 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. أما أعرف بأن The Gas Company قد تقدم معلوماتي إلى شركات خدمات أو مكاتب أخرى لإدراجي في برامج المساعدة الخاصة بهم.</p>	<p>التوقيع: X <input style="width: 100px; height: 30px; border: 1px solid black;" type="text"/></p> <p>التاريخ: <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/> / <input style="width: 20px; height: 15px; border: 1px solid black;" type="text"/></p>
--	--

3



20% CARE
ԶԵՂԻ ԴԻՄՈՒՄ



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

Խնդրվում է լրացնել և վերադարձնել դիմումը կամ դիմել առցանց՝ socialgas.com (Փնտրեք «CARE»)

ԻՆՉՊԵՍ ՊԱՅՄԱՆՈՒՆԱԿ ԴԱՌՆԱԼ ԶԵՂԻՆ

ՀԱՍԱՐԱԿԱԿԱՆ ՕԳՆՈՒԹՅԱՆ ԾՐԱԳԵՐԸ՝
Եթե դուք կամ ձեր ընտանիքից ուրիշ անդամ օգտվում եք հետևյալ ծրագրերից որևէ մեկից
Medicaid ԿԱՍ Medi-Cal, Healthy Families A&B, Women, Infants, & Children (WIC), CalWORKs (TANF) ԿԱՍ Tribal TANF, Head Start Income Eligible - Tribal Only, Bureau of Indian Affairs General Assistance, CalFresh / SNAP (Սննդի կտրոններ), National School Lunch Program (NSLP), Low Income Home Energy Assistance Program, Supplemental Security Income (SSI)

ԿԱՍ

ԱՌԱՎԵԼԱԳՈՒՅՆ ԸՆՏԱՆԵԿԱՆ ԵԿԱՄՈՒՏ՝ (ուժի մեջ է 2014 թ. հունվարի 1-ից մինչև 2014 թ. մայիսի 31-ը) *ներկա ընտանեկան եկամուտը բոլոր աղբյուրներից մինչև կրճատումները	
Ընտանիքի անդամների թիվը	Ընդհ. տարեկան եկամուտը
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Ընտանիքի յուրաքանչյուր լրացուցիչ անդամ	+\$8,040

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 պայմանուճակ չեք: / Ձեզանից կարող է խնդրվել ստուգել CARE-ի Ձեր պայմանուճակությունը:

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

Energy Savings Assistance Program - Ցածր եկամուտ ունեցող իրավասու տանտերերին և վարձակալներին անվճար կարգով առաջարկում է տան էներգախնայողության այնպիսի բարեկարգումներ, ինչպիսիք են առաստաղի մեկուսացումը, դռան եղանակային մերկացումը, գաջումն ու մանր տնային վերանորոգումներ: Լրացուցիչ տեղեկությունների համար խնդրում ենք զանգահարել 1-800-331-7593:



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

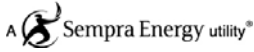
LIHEAP- Low Income Home Energy Assistance Program մատակարարում է հաշիվների վճարման օգնություն, վթարների օգնություն § եղանակի հետ կապված ծառայություններ: Զանգահարեք California Department of Community Services and Development 1-866-675-6623 հեռախոսի համարով:

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

ՀԱՃԱՍՈՐԴՆԵՐԻ ՕԺԱՆԴԱԿՈՒԹՅԱՆ ԼՈՒՑՈՒՑԻՉ ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐԻ ՀԱՍԱՐ՝

1-888-427-1345

Լսողության դժվարություն ունեցողներ (TDD/TTY): 1-800-252-0259 (միայն անգլերեն § իսպաներեն լեզուներով)
Ֆաքս: (213)244-4665



CARE 20% Գնային Ձեռչի Դիմում

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

Form 6491-D ARM (01/14)
CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA
90051-1249

1

Հաճախորդի Անուն՝
(ինչպես Ձեզ ուղարկվող հաշիվներում)

Տան հասցե՝
(փողոց, քաղաք, ԻՆՂԵՔՍ)

Հաշվեհամար՝

Հեռախոսահամար՝ () -

Էլեկտրոնային հասցե՝

2

Ձեր ընտանիքում մեծահասակների և երեխաների ընդհանուր թիվը՝

1 2 3 4 5 6 6+:

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

- ԱՅՈ** (Եթե այո, ապա նշեք որ ծրագր(եր)ին եք մասնակցում ▼
 - Medi-Cal / Medicaid: մինչև 65 տարեկան
 - Low Income Home Energy Assistance Program (LIHEAP)
 - Medi-Cal / Medicaid: 65 տարեկան կամ ավել
 - Supplemental Security Income (SSI)
 - Healthy Families Categories A & B
 - National School Lunch Program (NSLP)
 - Women, Infants, and Children Program (WIC)
 - Bureau of Indian Affairs General Assistance (BIA GA)
 - CalWORKs (TANF) ԿԱՍ Tribal TANF
 - Head Start Income Eligible - Tribal Only
 - CalFresh / SNAP (Սննդի կտրոններ)

- ՈՉ**

Որքա՞ն է Ձեր տարեկան ընտանեկան եկամուտը (մինչև կրճատումները՝ ընտանիքի բոլոր անդամներին ներառյալ) ▼

\$0-\$22,980 \$22,981-\$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101- \$55,140

Եթե \$55,140-ից ավել է, ապա գումարը մուտքագրեք այստեղ. \$, 00 տարեկան

Խնդրվում է նշել Ձեր եկամտի աղբյուրները. ▼

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

3

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

Ստորագրություն՝ **X** Ամսաթիվ՝ / /

برنامه نرخهای جایگزین شرکت گاز در کالیفرنیا برای نیرو (CARE) جهت خانوارهای واجد شرایط، 20% تخفیف در قبض ماهیانه گاز. آنهایی که واجد شرایط بوده و در ظرف 90 روز از شروع اشتراک جدید گاز مورد تایید قرار گیرند، همچنین 15 دلار تخفیف در هزینه راه اندازی خدمات دریافت خواهند کرد. تخفیف زمانی تعلق می گیرد که تقاضانامه تکمیل و امضاء شده شما توسط The Gas CompanySM تصویب شده باشد.

لطفاً این تقاضا نامه را کامل کرده و به سایت اینترنتی (تارنما) socialgas.com مراجعه کرده "CARE" را جستجو کنید.

چگونه می توانید واجد شرایط تخفیف مراقبت (CARE DISCOUNT) شوید:

حداکثر درآمد خانوار*:	
(تاریخ اعتبار از 1 ماه ژانویه 2014 الی 31 ماه می 2014)	
* درآمد کنونی خانوار شامل تمام منابع درآمد قبل از کسورات	
تعداد افراد در خانوار	کل درآمد سالانه
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
برای هر عضو بیشتر در خانوار این مبلغ را بیافزایید	+\$8,040

برنامه های کمک عمومی:
اگر شما و یا شخص دیگری در خانوار شما در یکی از برنامه های زیر شرکت می کند:
مدی کید (Medicaid), مدیکال (Medi-Cal), خانواده های تندرست الف و ب (Healthy Families A&B) یا رانه برنامه تغذیه برای زنان، نوزادان و کودکان (Women, Infants & Children (WIC))
کمک موقت به خانواده های نیازمند (CalWORKs (TANF))
کمک های موقت به قبایل سرخپوستان (Tribal TANF)
واجدین شرایط درآمد "هداستارت" (Head Start) مختص قبایل نهاد کمک های عمومی امور سرخپوستان (کوپن غذائی) (CalFresh /SNAP)
برنامه ملی ناهار رایگان در مدارس (NSLP)
برنامه کمک نیروی مسکن برای افراد کم درآمد (LIHEAP)
یارانه درآمد تأمین اجتماعی (SSI)

یا

شرایط برای شرکت کردن

قبض گاز باید به نام شما و آدرس باید آدرس اصلی شما باشد / کسی به غیر از مسروران نباید شما را به عنوان وابسته در گزارش مالیات بر درآمد خویش ادعا کرده باشد / شما باید تقاضانامه خود را در صورتی از شما خواستار شوند مجدداً تایید نمایید / اگر دیگر واجد شرایط نباشید می بایست شرکت The Gas Company را ظرف 30 روز مطلع سازید / ممکن است از شما خواسته شود تا صلاحیت خود را برای CARE نشان دهید.

Energy Savings Assistance Program

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

برنامه کمک برای صرفه جویی نیرو: بهینه سازی رایگان مسکن برای صرفه جویی نیرو، به شمول عایق سازی سقف، روزنه گیری درب، درزگیری و تعمیرات جزئی منزل، در اختیار صاحبان منازل یا مستأجرین کم درآمد که واجد شرایط باشند قرار می دهد. برای اطلاعات بیشتر با این شماره تماس بگیرید: 1-800-331-7593

Medical Baseline: این برنامه مقادیر بیشتری گاز را با نرخ نازلتر برای مشتریان دچار بیماری های خاص فراهم می کند. برای اطلاعات بیشتر با شماره 1-800-427-2200 تماس بگیرید.

LIHEAP: برنامه کمک نیروی مسکن برای افراد کم درآمد، خدمات کمک پرداخت قبض، کمک پرداخت قبض در شرایط اضطراری، اقدامات جلوگیری از رسوخ تأثیرات آب و هوا و تعدیل مصرف نیرو در مسکن را ارائه می کند. با سازمان خدمات اجتماعی و عمران کالیفرنیا (California Dept. of Community Services and Development) به شماره 1-866-675-6623 تماس بگیرید.

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

برای اطلاعات بیشتر در مورد کمک به مشتریان:

1-888-427-1345


اشخاصی که مشکل شنوایی دارند (Hearing Impaired (TDD/TTY)) 1-800-252-0259 (صرفاً به زبان های انگلیسی و اسپانیولی در دسترس می باشد) فکس: 4665-244 (213)

تقاضا نامه تخفیف نرخ مراقبت (CARE) 20%

لطفا با جوهر تیره رنگ و حروف درشت و خوانا بنویسید تا رسیدگی مناسب تضمین گردد
روش صحیح برای پر کردن دایره ها: ●

Form 6491-D FAR (01/14)
CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1	نام و نام خانوادگی مشتری (به صورتی که روی قبض شما درج شده است): نشانی منزل (خیابان، شهر، کد پستی): شماره حساب: <input style="width: 100px;" type="text"/> شماره تلفن: <input style="width: 100px;" type="text"/> نشانی پست الکترونیک یا ایمیل: <input style="width: 100%; height: 20px;" type="text"/>
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2		جمع کل افراد بزرگسال و کودکان در خانوار شما: <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"/> بیشتر از 6					
<p style="text-align: center;">آیا شما (یا یکی از اعضای خانوارتان) برای یکی از برنامه‌های کمک ذیل نام نویسی کرده اید؟</p> <p style="text-align: center;">● بله (اگر پاسختان بلی است، برنامه (ها) بی را که در آن شرکت میکنید علامت بگذارید) ▼</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/> برنامه یارانه نیروی مسکن برای افراد کم درآمد (LIHEAP) <input type="checkbox"/> یارانه درآمد تأمین اجتماعی (SSI) <input type="checkbox"/> برنامه ملی ناهار رایگان در مدارس (NSLP) <input type="checkbox"/> نهاد کمک‌های عمومی امور سرخپوستان (BIA GA) <input type="checkbox"/> واجدین شرایط درآمد "هداستارت" (Head Start) مختص قبایل سرخپوستان </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> مدی کل/ مدی کید: زیر سن 65 <input type="checkbox"/> مدی کل/ مدی کید: 65 یا بالاتر <input type="checkbox"/> گروه‌های A و B برنامه خانواده‌های سالم <input type="checkbox"/> برنامه زنان، نوزادان، و کودکان (WIC) <input type="checkbox"/> CalWORKs (TANF) کمک موقت به نیازمند، یا TANF قبایل سرخپوستان <input type="checkbox"/> CalFresh /SNAP (کوپن غذایی) </td> </tr> </table> <p style="text-align: right;">خیر ●</p> <p style="text-align: center;">در آمد سالانه خانوار شما چه مقدار می‌باشد (پیش از کسورات مالیاتی، به شمول تمامی اعضای خانوار)؟ ▼</p> <p style="text-align: center;"> <input type="radio"/> \$0 - \$22,981 <input type="radio"/> \$22,981 - \$31,021 <input type="radio"/> \$31,021 - \$39,061 <input type="radio"/> \$39,061 - \$47,101 <input type="radio"/> \$47,101 - \$55,140 </p> <p style="text-align: center;">اگر بیشتر از \$55,140 می‌باشد مبلغ را در اینجا بنویسید: \$ <input style="width: 100px;" type="text"/>.00 در سال</p> <p style="text-align: center;">▼ خواهشمند است منابع در آمد خود را علامت بگذارید:</p> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"> <input type="checkbox"/> سوشال سکوریتی <input type="checkbox"/> SSP or SSDI <input type="checkbox"/> حقوق های بازنشستگی <input type="checkbox"/> سود یا در آمد سهام از: حسابهای پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> دستمزد و/یا حقوق از کار آزاد <input type="checkbox"/> مزایای بیکاری <input type="checkbox"/> غرامت‌های بیمه یا حقوقی <input type="checkbox"/> پرداخت‌های از کار افتادگی یا پرداخت‌های بیمه کارکنان </td> <td style="width: 33%; border: none;"> <input type="checkbox"/> نفقه همسر یا کودک <input type="checkbox"/> بورس‌های تحصیلی، وچوه هدیه شده <input type="checkbox"/> بلاعوض، یا هر اعانه دیگر مصرفی برای هزینه سکونت <input type="checkbox"/> در آمد از کرایه دادن یا حق الامتياز <input type="checkbox"/> پول نقد یا هر نوع در آمد دیگر </td> </tr> </table>			<input type="checkbox"/> برنامه یارانه نیروی مسکن برای افراد کم درآمد (LIHEAP) <input type="checkbox"/> یارانه درآمد تأمین اجتماعی (SSI) <input type="checkbox"/> برنامه ملی ناهار رایگان در مدارس (NSLP) <input type="checkbox"/> نهاد کمک‌های عمومی امور سرخپوستان (BIA GA) <input type="checkbox"/> واجدین شرایط درآمد "هداستارت" (Head Start) مختص قبایل سرخپوستان	<input type="checkbox"/> مدی کل/ مدی کید: زیر سن 65 <input type="checkbox"/> مدی کل/ مدی کید: 65 یا بالاتر <input type="checkbox"/> گروه‌های A و B برنامه خانواده‌های سالم <input type="checkbox"/> برنامه زنان، نوزادان، و کودکان (WIC) <input type="checkbox"/> CalWORKs (TANF) کمک موقت به نیازمند، یا TANF قبایل سرخپوستان <input type="checkbox"/> CalFresh /SNAP (کوپن غذایی)	<input type="checkbox"/> سوشال سکوریتی <input type="checkbox"/> SSP or SSDI <input type="checkbox"/> حقوق های بازنشستگی <input type="checkbox"/> سود یا در آمد سهام از: حسابهای پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی	<input type="checkbox"/> دستمزد و/یا حقوق از کار آزاد <input type="checkbox"/> مزایای بیکاری <input type="checkbox"/> غرامت‌های بیمه یا حقوقی <input type="checkbox"/> پرداخت‌های از کار افتادگی یا پرداخت‌های بیمه کارکنان	<input type="checkbox"/> نفقه همسر یا کودک <input type="checkbox"/> بورس‌های تحصیلی، وچوه هدیه شده <input type="checkbox"/> بلاعوض، یا هر اعانه دیگر مصرفی برای هزینه سکونت <input type="checkbox"/> در آمد از کرایه دادن یا حق الامتياز <input type="checkbox"/> پول نقد یا هر نوع در آمد دیگر
<input type="checkbox"/> برنامه یارانه نیروی مسکن برای افراد کم درآمد (LIHEAP) <input type="checkbox"/> یارانه درآمد تأمین اجتماعی (SSI) <input type="checkbox"/> برنامه ملی ناهار رایگان در مدارس (NSLP) <input type="checkbox"/> نهاد کمک‌های عمومی امور سرخپوستان (BIA GA) <input type="checkbox"/> واجدین شرایط درآمد "هداستارت" (Head Start) مختص قبایل سرخپوستان	<input type="checkbox"/> مدی کل/ مدی کید: زیر سن 65 <input type="checkbox"/> مدی کل/ مدی کید: 65 یا بالاتر <input type="checkbox"/> گروه‌های A و B برنامه خانواده‌های سالم <input type="checkbox"/> برنامه زنان، نوزادان، و کودکان (WIC) <input type="checkbox"/> CalWORKs (TANF) کمک موقت به نیازمند، یا TANF قبایل سرخپوستان <input type="checkbox"/> CalFresh /SNAP (کوپن غذایی)						
<input type="checkbox"/> سوشال سکوریتی <input type="checkbox"/> SSP or SSDI <input type="checkbox"/> حقوق های بازنشستگی <input type="checkbox"/> سود یا در آمد سهام از: حسابهای پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی	<input type="checkbox"/> دستمزد و/یا حقوق از کار آزاد <input type="checkbox"/> مزایای بیکاری <input type="checkbox"/> غرامت‌های بیمه یا حقوقی <input type="checkbox"/> پرداخت‌های از کار افتادگی یا پرداخت‌های بیمه کارکنان	<input type="checkbox"/> نفقه همسر یا کودک <input type="checkbox"/> بورس‌های تحصیلی، وچوه هدیه شده <input type="checkbox"/> بلاعوض، یا هر اعانه دیگر مصرفی برای هزینه سکونت <input type="checkbox"/> در آمد از کرایه دادن یا حق الامتياز <input type="checkbox"/> پول نقد یا هر نوع در آمد دیگر					

3	<p>آیا با محتوی متن ذیل موافق هستید؟ خواهشمند است متن را خوانده، در ذیل امضاء کنید:</p> <p>اظهار می کنم اطلاعاتی را که در این تقاضا نامه ارائه داده ام صحیح و درست هستند. موافقت می کنم اگر از من خواسته شود، مدارک اثبات واجد شرایط بودن CARE را ارائه کنم. موافقت می کنم اگر دیگر واجد شرایط دریافت تخفیف نباشم، به شرکت The Gas Company اطلاع دهم. آگاه هستم اگر بدون داشتن شرایط لازمه تخفیف دریافت کنم، ممکن است ادار به پس دادن تخفیف دریافتی بشوم. آگام شرکت The Gas Company می تواند اطلاعات مربوطه مرا با سایر شرکت های آب یا برق یا گاز یا عاملین جهت نام نویسی اینجانب در برنامه های یارانه آنها در میان بگذارد.</p> <p style="text-align: right;">امضاء: <input checked="" type="checkbox"/> <input style="width: 100px;" type="text"/></p> <p style="text-align: center;">تاریخ: <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/> / <input style="width: 30px;" type="text"/></p>
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CARE DAIM NTAWV THOV KEV PAB LUV NQI 20%



Lub Lag Luam Tso Roj Zeb Ntsuam (The Gas Company) txoj kev pab cuam Lwm Cov Nqi Hluav Taws Xob Hauv California (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 tsim nyog tau. Cov tsev neeg tsim nyog tau thiab cov uas tau txais qhov kev pab no ua ntej 90 hnub txij li pib siv hluav taws xob tshiab yuav tau \$15 luv nqi ntiv ntawm Tus Nqi Txuas Hluav Taws Xob. Yuav pib luv nqi thaum twg koj sau tiav thiab kos npe tas rau tsab ntawv thov kev pab thiab lub Lag Luam Tso Roj Zeb Ntsuam (The Gas CompanySM) tau pom zoo tag.

Thov sau kom txhij thiab muab tsab ntawv thov kev pab xa rov qab los yog ua ntawv mus thov kev pab saum huab cua ntawm socalgas.com (Nrhiav "CARE")

YUAV UA 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:
Kev Pab Them Nqi Kho Mob Medicaid los sis Medi-Cal Healthy Families A&B
Nyiaj Pab Poj Niam thiab Menyuum Kev Noj Kev Haus (WIC)
CalWORKs (TANF) los sis Pab Pawg Neeg TANF
Tau Nyiaj Tsim Nyog Muab Me Nyuam Kawm Ntawv
Hauv Head Start (Pab Pawg Neeg Khab Xwb)
Nyiaj Pab Rau Cov Xwm Txheej Neeg Khab
CalFresh / SNAP (Nyiaj Muas Noj)
Lub Teb Chaws Txoj Kev Pab Su Noj Dawb Hauv Tsev Kawm Ntawv (NSLP)
Low Income Home Energy Assistance Program (Kev Pab Nqi Hluav Taws Xob)
Nyiaj Pab Neeg Tsis Taus (SSI)

LOS SIS

TUS NYIAJ TSI PUB TSEV NEEG TAU DHAU*: <i>(Pib siv txij lub Ib Hlis Ntuj Tim 1, 2014 mus rau Tej zaum 31, 2014)</i>	
*tag nrho tsev neeg txhua hom nyiaj khwv tau ua ntej rho tawm nqi se	
Pes Tsawg Leej Nyob Hauv Lub Tsev	Tag Nrho Cov Nyiaj Khwv Tau Ib Xyoods
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Ib Tug Neeg Twg Ntxiv	+\$8,040

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. / Yuav tsum tsis muaj lwm tus neeg uas koj npe ua se nrog tsuas yog koj tus txij nkawm xwb. / Koj yuav tsum rov qab muab tsab ntawv thov kev pab ua tshiab dua thaum twg nug txog. / Koj yuav tsum hu cuag Lub Lag Luam Tso Roj Zeb Ntsuam (The Gas Company) tsis pub dhau 30 hnub yog tias koj tsis tsim nyog tau cov kev pab no lawm. / Yuav nug kom muab ntaub ntawv pov thawj txog koj txoj kev tsim nyog tau cov kev pab CARE.

LWM HOM KEV PAB CUAM THIAJ KEV PAB TXHAWB UAS TEJ ZAUM KOJ YUAV TSIM NYOG TAU:

Kev Pab Txuag Nyiaj (Energy Savings Assistance Program): Muaj kev pab txhim kho rau hauv vaj hauv tsev kom txhob siv hluav taws xob xws li ntsaws rwb rau qaum tsev, ntsaws kis qhov rooj, ntsaws kis kaum vaj kaum tsev thiab kho vaj tse me ntsis rau cov neeg yuav tsev thiab xauj tsev nyob uas tau nyiaj tsawg. Xav paub ntxiv, thov hu rau 1-800-331-7593.



Txoj Kev Pab Nyiaj Them Nqi Kho Mob (Medical Baseline) – Pab nyiaj ntxiv them nqi roj tsheb phee yig dua rau cov neeg muaj qee hom kev mob nkeeg. Xav paub ntxiv, hu rau 1-800-427-2200.

LIHEAP - Kev Pab Cov Tsev Neeg Tau Nyiaj Hlis Tsawg (Low Income Home Energy Assistance Program) pab them me ntsis nuj nqis, pab them nqi kub ceev thiab kev kho ntsaws vaj tse kom tiv taus huab cua. Hu rau lub koom haum California Tuam Tsev Tswg Xyuas Kev Pab Txhawb thiab Tsim Zej Zog (California Department of Community Services and Development) ntawm 1-866-675-6623.

California Xov Tooj Cawm Siav (Lifeline) – Ib qho kev xaim xov tooj kom phee yig rau tej cov neeg muaj nyiaj tsawg sib xws li CARE. Xav paub ntxiv, hu rau koj lub lag luam txuas xov tooj.

YOG XAV PAUB NTXIV TXOG KEV PAB NEEG:

1-888-427-1345

Rau Cov Tsis Hnov Lus Zoo (TDD/TTY): 1-800-252-0259 (muaj rau hom lus Askiv thiab lus Mev xwb)
Fej: (213)244-4665



CARE TSAB NTAUV THOV KEV PAB LUV NQI 20%

Thov siv ib tug cwj mem DUB DUB sau thiab txhob sau ntawv sib cab kom txhob muaj teeb meem lis.

Form 6491-D HMO (01/14)

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

Txoj Kev Kos Lub Voj Kom Yog



1

Neeg Qhua Lub Npe
(raws li tshwm nram koj daim nqi):

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

Txhooj Zauv:

Tus Xov tooj: () -

Chaw Sau Ntawv E-mail:

2

Tag nrho cov neeg laus thiab me nyuam hauv koj lub tsev: 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, kos qhia (cov) hom kev pab tau koom nrog) ▼

- Medi-Cal / Medicaid: Hnub Nyooq Qis Dua 65
- Medi-Cal / Medicaid: 65 xyoos los Laus Dua
- Healthy Families Categories A & B
- Nyiaj Pab Poj Niam thiab Me Nyuam Kev Noj Kev Haus (WIC)
- CalWORKs (TANF) los sis Pab Pawg Neeg TANF
- CalFresh / SNAP (Nyiaj Muas Noj)
- Kev Pab Cov Tsev Neeg Tau Nyiaj Hlis Tsawg (Low Income Home Energy Assistance Program) (LIHEAP)
- Nyiaj Pab Neeg Tsis Taus (SSI)
- Lub Teb Chaws Txoj Kev Pab Su Noj Dawb Hauv Tsev Kawm Ntawv (NSLP)
- Nyiaj Pab Rau Cov Xwm Txheej Neeg Khab (Bureau of Indian Affairs General Assistance) (BIA GA)
- Tau Nyiaj Tsim Nyog Muab Me Nyuam Kawm Ntawv Hauv Head Start (Pab Pawg Neeg Khab Xwb)

TSIS MUAJ

Koj qhov nyiaj khwv tau ib xyoos tau npaum li cas (ua ntej txiav cov nqi se, qhia tag nrho nyiaj ntawm txhua tus neeg hauv lub tsev)? ▼

0 - \$22,980 \$22,981-\$31,020 \$31,021- \$39,060 \$39,061- \$47,100 \$47,101 - \$55,140

Yog tias tau ntau tshaj \$55,140, sau tias tau pes tsawg rau ntawm no: \$, .00 tauj ib xyoos

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

- Nyiaj Laus (Social Security)
- Nyiaj Pab SSP los sis SSDI
- Nyiaj Laus (Pensions)
- Nyiam Paj Laum los yog Nyiaj Lag Luam Faib tau ntawm: Cov Nyiaj Txuag Cia, Cov Nyiaj Tso Ua Lag Luam (Stocks), Cov Nyiaj Cia Tseg (Bonds) los yog Cov Txhooj Cia Nyiaj Rau Yav Laus (Retirement Accounts)
- Cov Nyiaj Khwv Tau thiab/los yog Peev tau los ntawm Kev Ua Hauj Lwm Rau Tus Kheej
- Nyiaj poob hauj lwm
- Nyiaj Hais Plaub Ntug Yeej
- Nyiaj Tsis Taus los yog Nyiaj Ua Hauj Lwm Raug Mob
- Nyiaj Yug Qub Txij Nkawm los yog Yug Me Nyuam
- Nyiaj pab them nqi kawm ntawv, nyiaj pab, los yog lwm cov nyiaj pab tau los siv ua lub neej
- Nyiaj Tau Los Ntawm Tsev Khiav Nqi los yog Nyiaj Faib Los Ntawm Tswv Lag Luam
- Nyiaj Ntsuab los sis Lwm Hom Nyiaj

3

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

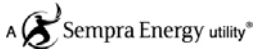
Kuv cog lus tias cov ncauj lus kuv tau sau nyob rau tsab ntawv thov kev pab no muaj tseeb thiab muaj tiag. Kuv pom zoo yuav npaj cov ntau ntawv pov thawj kev tsim nyog tau kev pab rau CARE thaum nug txog. Kuv lees yuav qhia rau Lub Lag Luam Tso Roj Zeb Ntsuam (The Gas Company) yog thaum kuv tsis tsim nyog tau cov kev pab no lawm. Kuv to taub tias yog kuv tau txais cov kev pab no yam tsis tsim nyog, kuv yuav tau them cov nqi lov tawm rov qab. Kuv to taub tias Lub Lag Luam Tso Roj Zeb Ntsuam (The Gas Company) muaj cai muab kuv cov ntau ntawv mus rau lwm lub lag luam tso hluav taws xob saib kom lawv muab kuv tso rau lawv cov kev pab.

Kos Npe: **X**

Hnub Tim: / /



ពាក្យសុំចុះតម្លៃ 20 ភាគរយ ពីកម្មវិធីវិលវេរ (CARE)



កម្មវិធីនៃតម្លៃថាមពលនាវាជីវិត (California Alternate Rates for Energy - CARE) របស់ក្រុមហ៊ុនហ្គាស The Gas CompanySM ផ្តល់ការចុះតម្លៃ 20 ភាគរយនៃការចុះតម្លៃចំពោះសំបុត្រ ទារលុយសំរាប់ផ្ទះសំបែងណាដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីនេះ ។ លោកអ្នកដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួល ហើយ ត្រូវបានអនុញ្ញាតក្នុងកំឡុង 90 ថ្ងៃនៃការចាប់ផ្តើមសេវាកម្មហ្គាសថ្មី ក៏នឹងទទួលបានការចុះតម្លៃ \$15 នៃតម្លៃតម្កើងស្ថាបនាសេវាកម្ម (Service Establishment Charge) ។ ការចុះតម្លៃ នឹងអនុវត្តពេលលោកអ្នកបំពេញ និងចុះហត្ថលេខាពាក្យសុំនេះ ត្រូវបានសំរេចដោយក្រុមហ៊ុនហ្គាស The Gas Company។

សូមបំពេញ និងផ្ញើពាក្យសុំមកវិញ ឬដាក់ពាក្យសុំតាមបណ្តាញ socialgas.com (Search "CARE")

មធ្យោបាយដើម្បីនឹងមានលក្ខណៈគ្រប់គ្រាន់ទទួលសំរាប់ការចុះតម្លៃ :

កម្មវិធីជំនួយសាធារណៈ
បើលោកអ្នក ឬនរណាម្នាក់ទៀតនៅក្នុងផ្ទះរបស់លោកអ្នក ចូលរួមកម្មវិធីណាមួយដូចតទៅ :
មេឌីខេត មេឌីខាល
សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
ស្ត្រី ទារក ហើយនិង កុមារ (WIC)
ខណ្ឌិក (CalWORKs (TANF)) ទ្រឹមលតែនហ្វ (Tribal TANF)
ឬ សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច
ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance)
ខណ្ឌស្រោចស្រាវ CalFresh / SNAP (Food Stamps)
កម្មវិធីអាហារថ្ងៃត្រង់ស្រីសាលាជំនួយសំរាប់កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch Program - NSLP)
កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
ចំណូលសេដ្ឋកិច្ចបន្ថែម (Supplemental Security Income - SSI)

ចំណូលគ្រួសារអតិបរមា *:	
<i>(មានប្រសិទ្ធភាពនៅក្នុងថ្ងៃទី 1 មករា 2014 ដល់ថ្ងៃទី 31 ឧសភា 2014)</i>	
*ចំណូលគ្រួសារបច្ចុប្បន្នមកពីប្រភពទាំងអស់មុនពេលកាត់ទុក	
ចំនួននៃមនុស្សរស់នៅក្នុងផ្ទះ:	ចំនួនថវិកាប្រចាំខែ
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,720
8	\$79,260
មនុស្សម្នាក់ៗបន្ថែម	+\$8,040

លក្ខខណ្ឌចំពោះការចូលរួម

សំបុត្រទារលុយហ្គាសត្រូវតែមានឈ្មោះ និងអាសយដ្ឋានរបស់លោកអ្នក ហើយត្រូវតែមានអាសយដ្ឋានចម្រើនរបស់លោកអ្នក ។ / លោកអ្នកមិនត្រូវធ្វើដាក់ឈ្មោះកូនជាតូចបិតនៅក្នុងបន្ទុកសំអាងទៅលើថវិកានៃនរណាម្នាក់ទៀត ជាជាងប្រពន្ធឬប្តីរបស់លោកអ្នកឡើយ ។ / លោកអ្នកត្រូវតែដាក់ស្នើសុំការបញ្ជាក់ម្តងទៀតចំពោះពាក្យសុំរបស់លោកអ្នកនៅពេលស្នើសុំ ។ / លោកអ្នកត្រូវតែប្រាប់ក្រុមហ៊ុនហ្គាស (The Gas Company) អោយដឹងយ៉ាងហោចណាស់ 30 ថ្ងៃ បើលោកអ្នកផ្តានលក្ខណៈគ្រប់គ្រាន់ទទួលបានទៀត ។ / លោកអ្នកប្រហែលជាត្រូវបានស្នើសុំអោយបញ្ជាក់នូវលក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីវិលវេរ (CARE) របស់លោកអ្នក។

កម្មវិធី និងសេវាកម្មទៀត ដែលលោកអ្នកមានលក្ខណៈគ្រប់គ្រាន់ទទួលនឹងទទួល :

កម្មវិធីផ្តល់ជំនួយសន្សំសំចៃថាមពល (Energy Savings Assistance Program) : ផ្តល់ការកែលម្អផ្ទះសំបែងសន្សំសំចៃថាមពលដោយមិនអស់លុយដូចជា ការដាក់ទ្រនាប់នៅលើពិភាន បន្ទះបិទបង្ហាតាមគុណភាពតាមចន្លោះទ្វារ ការបិទថ្នាំការបិទ និងការជួសជុល តិចតួចនៃផ្ទះសំបែងដែលទាំងមូល និងអ្នកផ្តល់ដែលមានប្រាក់ចំណូលទាប។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-800-331-7593 ។



ម៉ាឌីខាល បេសឡាញ (Medical Baseline) : ផ្តល់ជាប្រាក់ជំនួយ ខាងហ្គាសដោយមានតម្លៃថោកចំពោះអ្នកទិញ ដែលមានលក្ខខណ្ឌសុខភាពជាក់លាក់។ សំរាប់ព័ត៌មាន បន្ថែម សូមទូរស័ព្ទលេខ 1-800-427-2200។

លីហ្វេប្រ (LIHEAP) : កម្មវិធីជំនួយខាងថាមពលនៃផ្ទះសំបែងដែល មានថវិកាតិច ផ្តល់ជាជំនួយខាងសំបុត្រទារលុយ ជំនួយខាងសំបុត្រទារលុយបន្តាន់ ហើយនិងសេវាកម្ម ខាងដោះស្រាយគុណភាព។ ទូរស័ព្ទ ក្រសួងសេវាកម្មសហគមន៍រដ្ឋកាលីហ្វ័រញ៉ា (California Dept. of Community Services) លេខ 1-866-675-6623 ។

ខ្សែទំនាក់ទំនងរដ្ឋកាលីហ្វ័រញ៉ា (California Lifeline): លទ្ធភាពចំពោះទូរស័ព្ទដោយមានតម្លៃថោក សំរាប់អ្នកទិញដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានបំពេញតាមការណែនាំពីចំណូលរបស់កម្មវិធីវិលវេរ (CARE)។ សំរាប់ព័ត៌មានបន្ថែម សូមទាក់ទងអ្នកផ្តល់សេវាកម្មខាង ទូរស័ព្ទប្រចាំស្រុករបស់លោកអ្នក ។

សំរាប់ព័ត៌មានអំពីជំនួយអតិថិជន:
1-888-427-1345

ខូតត្រចៀក (TDD/TTY): 1-800-252-0259 (ជាភាសាអង់គ្លេស និង អេស្ប៉ាញប៉ុណ្ណោះ)
ទូរសារ (213)244-4665



ពាក្យសុំចុះតម្លៃ 20% នៃកម្មវិធីវិលែរ (CARE)

Form 6491-D KH (01/14)
CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051

សូមប្រើទឹកបិទខ្មៅ ហើយសរសេរដោយផ្អែកលើការបញ្ជាក់ដំណើរការយ៉ាងត្រឹមត្រូវ



វិធីត្រឹមត្រូវគូសរង្វង់មូល: ●

1	ឈ្មោះរបស់អ្នកទិញ (ដូចមានលើសំបុត្រទារលុយ):	
	អាសយដ្ឋាន (រដ្ឋ ក្រុង កូដស៊ីប័រ):	
	លេខកុង:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	លេខទូរស័ព្ទ:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	អាសយដ្ឋានអ៊ីមែល:	<input type="text"/>

2	ចំនួនមនុស្សពេញវ័យ និងក្មេងក្នុងគ្រួសាររបស់លោកអ្នកសរុប:	<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="checkbox"/>
	តើលោកអ្នក (វិនិច្ឆ័យក្នុងគ្រួសាររបស់លោកអ្នក) ចូលរួមក្នុងកម្មវិធីជំនួយណាមួយខាងក្រោមនេះ?	
<input type="radio"/> មាន បើមាន សូមគូសកម្មវិធីជំនួយ (ជ្រើសរើស) ▼		
<ul style="list-style-type: none"> <input type="checkbox"/> មេឌីខេត/មេឌីខាល: ក្រោម 65 ឆ្នាំ <input type="checkbox"/> មេឌីខេត/មេឌីខាល: លើ 65 ឆ្នាំ រ៉ាលីសនេះ <input type="checkbox"/> សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B <input type="checkbox"/> កម្មវិធីស្ត្រី ទារក ហើយនិង កុមារ (WIC) <input type="checkbox"/> ខណ្ឌរីក (CalWORKs [TANF]) ទ្រឹបលតែនហ្វូ (Tribal TANF) <input type="checkbox"/> ខណ្ឌប្រេស CalFresh / SNAP (Food Stamps) <input type="checkbox"/> កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP) <input type="checkbox"/> ចំណូលសេដ្ឋកិច្ចបន្ថែម (Supplemental Security Income - SSI) <input type="checkbox"/> កម្មវិធីអាហារថ្ងៃត្រង់ស្ថិតនៅក្នុងសាលាជាតិ (National School Lunch Program - NSLP) <input type="checkbox"/> ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance - BIA GA) <input type="checkbox"/> សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច 		
<input type="radio"/> មិនមាន		
តើចំណូលគ្រួសារប្រចាំឆ្នាំរបស់លោកអ្នក (មុនពេលកាត់ រួមសមាជិកគ្រួសារទាំងអស់) មានប៉ុន្មាន? ▼		
<input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140		
<input type="radio"/> បើច្រើនជាង 55,140 សូមបញ្ចូលចំនួននៅទីនេះ : \$ <input type="text"/> , <input type="text"/> .00 ក្នុងមួយឆ្នាំ		
គូសយកប្រភពចំណូលរបស់លោកអ្នក: ▼		
<ul style="list-style-type: none"> <li style="width: 33%;"><input type="checkbox"/> សូស្យាល់សេដ្ឋកិច្ច <li style="width: 33%;"><input type="checkbox"/> ប្រាក់ខែ និង/ឬប្រាក់ចំណេញពីពាណិជ្ជកម្មផ្ទាល់ខ្លួន <li style="width: 33%;"><input type="checkbox"/> ប្រាក់ជំនួយពីប្តីឬប្រពន្ធ វិជ្ជមានកូន <li style="width: 33%;"><input type="checkbox"/> SSP ឬ SSDI <li style="width: 33%;"><input type="checkbox"/> ប្រាក់អត្ថប្រយោជន៍ពីការឥតការធ្វើ <li style="width: 33%;"><input type="checkbox"/> ប្រាក់ជំនួយអាហាររូបករណ៍ ជំនួយវិជ្ជមានទៀតប្រើសំរាប់ការថាយវាយនៃជីវភាព <li style="width: 33%;"><input type="checkbox"/> លុយវិគ្រួសារ <li style="width: 33%;"><input type="checkbox"/> ការប្រាក់ ឬកម្រៃហ៊ុនពី: កុងសន្សំ <li style="width: 33%;"><input type="checkbox"/> ប្រាក់មកពីអិរស៊ូរិន ឬប្រាក់មកពីការកាត់សេចក្តី <li style="width: 33%;"><input type="checkbox"/> ប្រាក់មកពីការជួល វិស្វយសារ <li style="width: 33%;"><input type="checkbox"/> ប្រាក់ Stocks, Bonds ឬលុយវិគ្រួសារ <li style="width: 33%;"><input type="checkbox"/> ប្រាក់ពីការ វិនិយោគកម្មករ <li style="width: 33%;"><input type="checkbox"/> ប្រាក់សុទ្ធ/ឬថវិកាទៀត 		

3	តើលោកអ្នកព្រមចំពោះការរៀបរាប់ខាងក្រោមទេ? សូមអាន ហើយចុះហត្ថលេខាខាងក្រោម ។	
	<p>ខ្ញុំសូមថ្លែងថាព័ត៌មានដែលខ្ញុំបានផ្តល់នៅក្នុងពាក្យសុំនេះ គឺពិតហើយត្រូវ ។ ខ្ញុំយល់ព្រមនឹងផ្តល់នូវភស្តុតាងសំរាប់លក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីវិលែរ (CARE) ប្រសិនបើខ្ញុំបានប្រើប្រាស់ប្រាក់កម្រៃហ៊ុនហ្គាស (The Gas Company) ប្រសិនបើខ្ញុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលបានកម្មវិធីវិលែរ (CARE) ។ ខ្ញុំយល់ថា បើខ្ញុំទទួលបានការចុះ ថោកដោយមិនមានលក្ខណៈគ្រប់គ្រាន់ទទួលបាន ខ្ញុំអាចត្រូវបានស្នើសុំដោយបង់សារការចុះថោកដែលខ្ញុំបានទទួល ។ ខ្ញុំយល់ថា ក្រុមហ៊ុនហ្គាស (The Gas Company) អាចចែកចាយព័ត៌មានរបស់ខ្ញុំជាមួយនិងក្រុមហ៊ុន និងភ្នាក់ងារទៀតដើម្បីចុះឈ្មោះខ្ញុំនៅក្នុងកម្មវិធីជំនួយរបស់គេ ។</p>	
ហត្ថលេខា: <input checked="" type="checkbox"/>		ថ្ងៃខែ: <input type="text"/> / <input type="text"/> / <input type="text"/>



ЗАЯВЛЕНИЕ НА ПОЛУЧЕНИЕ ЛЬГОТ В РАЗМЕРЕ 20% ПО ПРОГРАММЕ CARE

Программа штата Калифорния под названием Альтернативные тарифные ставки за пользование электроэнергией (California Alternate Rates for Energy, (CARE)) предлагаемая компанией The Gas Company предоставляет льготу в виде снижения оплаты счета за газ на 20% ежемесячно для семей, соответствующих установленным требованиям. Те семья, которые отвечают условиям программы и получили право на участие в ней, в течение 90 дней с начала получения новых услуг газоснабжения также получают льготу в виде снижения Сбора за установку услуг (Service Establishment Charge) на \$15. Льгота будет предоставлена после того, как ваше заполненное и подписанное заявление будет одобрено компанией The Gas CompanySM.

Пожалуйста, заполните и верните заявление по почте либо заполните его онлайн на вебсайте socialgas.com (разделе "CARE")

КАК УЗНАТЬ ОТВЕЧАЕТЕ ЛИ ВЫ УСЛОВИЯМ ЛЬГОТНОЙ ПРОГРАММЫ CARE:

ПРОГРАММЫ СОЦИАЛЬНОЙ ПОМОЩИ:
Если вы или кто-либо из проживающих с вами членов семьи получает льготы по одной из следующих программ:
Medicaid или Medi-Cal Healthy Families A&B Women, Infants, & Children (WIC) CalWORKs (TANF) или Tribal TANF Head Start Income Eligible - Только для коренного населения США Bureau of Indian Affairs General Assistance CalFresh / SNAP (Food Stamps) (Продовольственные талоны) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)

ИЛИ

МАКСИМАЛЬНЫЙ ДОХОД СЕМЬИ*: (действительно с 1 января 2014 г. по 31 мая 2014 *семейный доход в настоящий момент из всех источников без учета отчислений)	
Кол-во членов семьи	Общий годовой доход
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
На каждого дополнительного члена семьи добавьте	+\$8,040

УСЛОВИЯ ДЛЯ УЧАСТИЯ В ПРОГРАММЕ

Счет за газ должен быть оформлен на ваше имя и приходиться на ваш основной адрес. / Вы не должны быть оформлены иждивенцем в налоговой декларации какого-либо другого лица за исключением вашего супруга (супруги). / Вы должны удостоверить повторно ваше заявление по требованию. / Вы обязаны уведомить компанию The Gas Company в течение 30 дней, если вы больше не соответствуете требованиям программы. / От вас может потребоваться подтверждение того, что вы соответствуете установленным требованиям участия в программе CARE.

ДРУГИЕ ПРОГРАММЫ И УСЛУГИ, НА КОТОРЫЕ ВЫ МОЖЕТЕ ИМЕТЬ ПРАВО:

Energy Savings Assistance Program: Предлагает отвечающим требованиям участия в программе домовладельцам и лицам, арендующим жилье бесплатное энергосберегающее обустройство дома, например теплоизоляцию потолков, уплотнение дверных швов, заделку стыков, а также небольшие ремонтные работы. Для получения дополнительной информации, пожалуйста, звоните по телефону 1-800-331-7593.

Energy Savings
.....
Assistance Program

Medical Baseline: Предоставляет дополнительные льготы на газ по более низкому тарифу для клиентов с определенными медицинскими показаниями. Для получения дополнительной информации звоните по телефону 1-800-427-2200.

LINEAR: Энергетическая программа социальной помощи малообеспеченным семьям (Low Income Home Energy Assistance Program) предоставляет помощь в оплате счетов за бытовые услуги, оплате счетов при аварийных ситуациях и необходимых строительных работ с учетом климатических особенностей района. Позвоните в Отдел бытового обслуживания и развития штата Калифорния (California Dept. of Community Services and Development) по телефону 1-866-675-6623.

California Lifeline: Использование телефона по сниженным тарифам для клиентов, соответствующим требованиям программы CARE. Для получения дополнительной информации об этой услуге, пожалуйста, обратитесь к вашему местному поставщику телефонных услуг.

**ДЛЯ ПОЛУЧЕНИЯ ДОПОЛНИТЕЛЬНОЙ ИНФОРМАЦИИ ОБРАЩАЙТЕСЬ В ОТДЕЛ ПОМОЩИ КЛИЕНТАМ
ПО ТЕЛЕФОНУ: 1-888-427-1345 или ФАКСУ: (213) 244-4665**

С потерями слуха (TDD/TTY): 1-800-252-0259 (только на английском и испанском языках)



Заявление на получение льгот в размере 20% по программе CARE

Form 6491-D RU (01/14)

Пожалуйста, используйте **ТЕМНЫЕ** чернила и пишите разборчиво, для обеспечения точной обработки заявки
Правильный способ закрашивания кружков: ●

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249



1

Имя и фамилия клиента (так как это указано на вашем счете):

Домашний адрес (улица, город, индекс):

Номер счета:

Номер телефона: () -

Адрес электронной почты:

2

Общее число детей и взрослых членов семьи, проживающих с вами : 1 2 3 4 5 6 Если больше 6:

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

ДА (Если да, укажите соответствующую(ие) программу(ы)) ▼

<input type="radio"/> Medi-Cal / Medicaid: младше 65 лет	<input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)
<input type="radio"/> Medi-Cal / Medicaid: 65 лет и старше	<input type="radio"/> Supplemental Security Income (SSI)
<input type="radio"/> Healthy Families, категории 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"/> CalWORKs (TANF) или Tribal TANF	<input type="radio"/> Head Start Income Eligible - Только для коренного населения США
<input type="radio"/> CalFresh / SNAP (Food Stamps) (Продовольственные талоны)	

НЕТ

Укажите доход вашей семьи в год (без учета отчислений, включая доходы всех членов семьи, проживающих с вами). ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Если больше \$55,140, то укажите сумму здесь: \$.00 в год

Пожалуйста, укажите источники вашего дохода: ▼

<input type="radio"/> Social Security (Социальное пособие)	<input type="radio"/> Зарплата и/или доход от инд. предпр. деятельности	<input type="radio"/> Пособие на супруга (супругу) или алименты на ребенка
<input type="radio"/> SSP или SSDI	<input type="radio"/> Пособие по безработице	<input type="radio"/> Стипендии, гранты или иные компенсации на проживание
<input type="radio"/> Пенсии	<input type="radio"/> Страховые выплаты или выплаты по искам	<input type="radio"/> Доходы от аренды или гонорары
<input type="radio"/> Процентный доход или дивиденды: сберегательные счета, акции, облигации или пенсионные счета	<input type="radio"/> Пособие по инвалидности или компенсации за травмы на работе	<input type="radio"/> Наличные деньги или другая прибыль

3

Согласны ли вы со следующим? Пожалуйста, прочтите и распишитесь.
Я заявляю, что информация, которую я представил(а) в данном заявлении, является достоверной и правильной. Я даю свое согласие при необходимости предоставить подтверждение моего права на участие в программе CARE. Я обязуюсь уведомить компанию The Gas Company, если я не стану соответствовать требованиям, необходимым для получения льгот. В том случае, если я продолжу получать скидку, не соответствующую необходимым на то требованиям, от меня могут потребовать вернуть полученную скидку. Я отдаю себе отчет в том, что компании The Gas Company может передавать мою личную информацию другим поставщикам бытовых услуг или их представителям с целью моей последующей регистрации в их программах социальной помощи.

Подпись: _____ Дата: / /

APPLICATION PARA SA 20% NA DISKUWENTO SA CARE



Ang California Alternate Rates for Energy (CARE) program ng The Gas Company ay nagbibigay ng 20% diskuwento sa buwanang gas bill para sa mga karapat-dapat na sambahayan. Ang mga naging kwalipikado at naaprubahan sa loob ng 90 araw mula sa pag-uumpisa ng bagong serbisyong gas ay makakatanggap din ng \$15 na diskuwento sa Service Establishment Charge. Ibibigay ang diskuwento kapag naaprubahan ng The Gas CompanySM ang inyong kumpleto at nilagdaang application form.

Pakikumpleto at ibalik ang application o mag-apply online sa socialgas.com (Hanapin "CARE")

PAANO MAGING KWALIPIKADO PARA SA DISKUWENTONG CARE:

MGA PROGRAMANG NAGBIBIGAY NG TULONG SA MADLA:	MGA HANGGANAN NG KITA NG SAMBAHAYAN*: (<i>may-bisa Enero 1, 2014 hanggang Mayo 31, 2014</i>) *kasalukuyang kita ng sambahayan mula sa lahat ng pinagkukunan bago mga kabawasan																					
<p>Kung kayo o isa sa inyong mga kasambahay ay nakikilahok sa alinman sa mga sumusunod na programa:</p> <ul style="list-style-type: none"> Medicaid o Medi-Cal Healthy Families A&B Women, Infants & Children (WIC) CalWORKs (TANF) o Tribal TANF Head Start Income Eligible – Tribal Lamang Bureau of Indian Affairs General Assistance CalFresh / SNAP (Food Stamps) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI) 	<p>O</p> <table border="1"> <thead> <tr> <th>Bilang ng Tao sa Sambahayan</th> <th>Kabuuang Kita para sa Taon</th> </tr> </thead> <tbody> <tr><td>1</td><td>\$31,020</td></tr> <tr><td>2</td><td>\$31,020</td></tr> <tr><td>3</td><td>\$39,060</td></tr> <tr><td>4</td><td>\$47,100</td></tr> <tr><td>5</td><td>\$55,140</td></tr> <tr><td>6</td><td>\$63,180</td></tr> <tr><td>7</td><td>\$71,220</td></tr> <tr><td>8</td><td>\$79,260</td></tr> <tr><td>Bawat Dagdag na Tao</td><td>+\$8,040</td></tr> </tbody> </table>	Bilang ng Tao sa Sambahayan	Kabuuang Kita para sa Taon	1	\$31,020	2	\$31,020	3	\$39,060	4	\$47,100	5	\$55,140	6	\$63,180	7	\$71,220	8	\$79,260	Bawat Dagdag na Tao	+\$8,040	
Bilang ng Tao sa Sambahayan	Kabuuang Kita para sa Taon																					
1	\$31,020																					
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8	\$79,260																					
Bawat Dagdag na Tao	+\$8,040																					

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 hindi dapat 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:

Energy Savings Assistance Program: Nagbibigay ng libreng pagpapa-ayos ng bahay upang makatipid sa enerhiya gaya ng insulasyon sa kisame, weather-stripping sa mga pintuan, caulking at maliliit na pagkukumpuni ng bahay para sa mga karapat-dapat na may-ari ng bahay at mga nangungupahan. Para sa karagdagang impormasyon, mangyaring tumawag sa 1-800-331-7593.

**Energy Savings
Assistance Program™**

Medical Baseline: Nagbibigay ng karagdagang palabis na gas sa mas mababang presyo sa mga mamimili na may mga tiyak na kalagayang medikal. Upang makatanggap ng karagdagang impormasyon, makipag-alam sa 1-800-427-2200.

LIHEAP : Ang Low Income Home Energy Assistance Program ay nagbibigay ng tulong sa pagbayad ng kuwenta, tulong sa pagbayad ng mga kuwenta kapag may emerhensiya at mga serbisyo ukol sa weatherization. Makipag-alam sa California Department of Community Services and Development sa 1-866-675-6623.

California Lifeline: Paglapit sa CARE sa pamamagitan ng telepono na may diskuwento para sa mga mamimiling ang kita ay tumatalima sa mga kagayang tuntunin ukol sa kita. Upang makatanggap ng karagdagang impormasyon, makipag-alam sa inyong lokal na tagatustos ng serbisyong telepono.

UPANG MAKATANGGAP NG IMPORMASYON TUNGKOL SA TULONG PARA SA MAMIMILI:

1-888-427-1345

May Kakulangan ang Pandinig (TDD/TTY): 1-800-252-0259 (makukuha sa Ingles at Kastila lamang)
Fax: (213)244-4665



**Application para sa
CARE 20% Diskuwento sa Singil**
(Pakisuyong gumamit ng MADILIM na tinta at sumulat ng malinaw
upang makasiguro ng tamang paghanda)
Tumpak na pagmarka ng mga bilog: ●

Form 6491-D TAG (01/14)

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249



1

Pangalan ng Mamimili
(gaya ng nakalista sa kuwenta):

Tirahan
(kalye, lungsod, zip):

Numero ng Kuwenta:

Telepono: () -

E-mail Address:

2

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

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

Oo (Kung oo, markahan ang (mga) programa kung saan kayo nakikilahok) ▼

<input type="radio"/> Medi-Cal / Medicaid: Mas mababa kaysa Edad 65	<input type="radio"/> Low Income Home Energy Assistance Program (LIHEAP)
<input type="radio"/> Medi-Cal / Medicaid: 65 o higit	<input type="radio"/> Supplemental Security Income (SSI)
<input type="radio"/> Healthy Families mga kategoriya 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"/> CalWORKS (TANF) o Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Lamang
<input type="radio"/> CalFresh / SNAP (Food Stamps)	

HINDI

Ano ang taunang kita ng inyong pamamahay (bago mga pagbabawas, kasama ang kita ng lahat ng inyong mga kasambahay)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Kapag higit sa \$55,140, ilagay halaga dito: \$, .00 bawat taon

Pakisuyong markahan ang mga pinagkukunan ninyo ng kita: ▼

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

3

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

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

Lagda: **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

กรุณากรอกใบสมัครให้ครบถ้วนและส่งกลับ หรือสมัครผ่านระบบออนไลน์ที่ socialgas.com (ค้นหาโดยใช้คำว่า "CARE")
วิธีในการผ่านเกณฑ์สำหรับการรับส่วนลด THE CARE DISCOUNT:

โครงการสังคมสงเคราะห์: (PUBLIC ASSISTANCE PROGRAMS:)
ในกรณีที่ท่านหรือสมาชิกในครอบครัวได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้:
Medicaid หรือ Medi-Cal Healthy Families A&B โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC) CalWORKs (TANF) หรือ Tribal TANF Head Start Income Eligible - เฉพาะชนเผ่า Bureau of Indian Affairs General Assistance CalFresh / SNAP (แสดมมีอาหาร) โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSLP) โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)

หรือ

รายได้รวมสูงสุดของครัวเรือน*: (มีผลตั้งแต่ 1 มกราคม 2014 ถึง 31 พฤษภาคม 2014) *รายได้รวมปัจจุบันของครัวเรือนจากทุกแหล่งรายได้ก่อนหักลดหย่อนภาษี	
จำนวนสมาชิกในครัวเรือน	รายได้รวมต่อปี
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
สมาชิกในครัวเรือนที่เพิ่มเติมให้เพิ่มอีกคนละ	+\$8,040

ข้อกำหนดสำหรับผู้เข้าร่วมโครงการ

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

โครงการและบริการอื่นๆ ที่ท่านอาจผ่านเกณฑ์ในการเข้าร่วม:

Energy Savings Assistance Program: (โครงการช่วยเหลือด้านการประหยัดพลังงาน)

เป็นโครงการที่มอบความช่วยเหลือในการปรับปรุงบ้านเพื่อการประหยัดพลังงานโดยไม่เสียค่าใช้จ่าย เช่น การติดตั้งฉนวนใต้ฝ้าเพดาน การปิดช่องประตู การอุดรอยแตกกราว และการซ่อมแซมบ้านเล็กๆ น้อยๆ สำหรับเจ้าของบ้านและผู้เช่าบ้านที่มีรายได้น้อยซึ่งมีคุณสมบัติตามเกณฑ์ สำหรับข้อมูลเพิ่มเติม โปรดโทรมาที่ 1-800-331-7593

Medical Baseline: (โครงการบริการทางการแพทย์ขั้นพื้นฐาน)

โครงการนี้จะมอบสิทธิเพิ่มเติมในการใช้ก๊าซในอัตราต่ำกว่าราคาปกติแก่ผู้ใช้บริการที่มีอาการป่วยบางประเภท ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้ที่หมายเลข 1-800-427-2200

LIHEAP: Low Income Home Energy Assistance Program (โครงการความช่วยเหลือด้านพลังงานในบ้านสำหรับผู้มีรายได้น้อย)

โครงการนี้จะมอบความช่วยเหลือในการชำระค่าบริการ ความช่วยเหลือในการชำระค่าบริการในกรณีเกิดเหตุฉุกเฉินและการปรับปรุงอาคารเพื่อเพิ่มประสิทธิภาพในการประหยัดพลังงาน ท่านสามารถติดต่อสอบถามข้อมูลเพิ่มเติมที่สำนักงานบริการและการพัฒนาชุมชนแห่งรัฐแคลิฟอร์เนีย (California Department of Community Services and Development) ที่หมายเลขโทรศัพท์ 1-866-675-6623

California Lifeline: (โครงการส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยของรัฐแคลิฟอร์เนีย)

โครงการนี้จะมอบส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยอยู่ในเกณฑ์เดียวกับผู้มีสิทธิ์เข้าร่วมโครงการ CARE ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้จากผู้ให้บริการโทรศัพท์ในท้องถิ่นของท่าน

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.....
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สอบถามข้อมูลเพิ่มเติมได้ที่แผนกลูกค้าสัมพันธ์:

1-888-427-1345

แฟกซ์ (213)244-4665

สำหรับผู้ที่มีปัญหาในการฟังหรือหูหนวกกรุณาติดต่อ (TDD/TTY): 1-800-252-0259 (เฉพาะภาษาอังกฤษและภาษาสเปนเท่านั้น)

กรุณากรอกข้อมูลให้ครบถ้วนด้วยตัวบรรจงโดยใช้หมึกสีเข้ม

CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

ฝนทำเครื่องหมายวงกลม: ●

1	<p>ชื่อลูกค้า (ตามใบแจ้งหนี้):</p> <p>ที่อยู่ (ถนน, เมือง, รหัสไปรษณีย์):</p> <p>หมายเลขบัญชี: <input type="text"/></p> <p>หมายเลขโทรศัพท์: <input type="text"/></p> <p>อีเมล: <input type="text"/></p>																																	
2	<p>จำนวนสมาชิกทั้งหมด ในครัวเรือนของท่าน: <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="checkbox"/></p> <p>ท่าน (หรือสมาชิกในครัวเรือนของท่าน) ได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้หรือไม่?</p> <p><input type="radio"/> YES (ถ้าใช่ ทำเครื่องหมายทุกโครงการที่เข้าร่วม) ▼</p> <table border="0"><tr><td><input type="radio"/> Medi-Cal / Medicaid: อายุน้อยกว่า 65 ปี</td><td><input type="radio"/> โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP)</td></tr><tr><td><input type="radio"/> Medi-Cal / Medicaid: อายุ 65 ปีขึ้นไป</td><td><input type="radio"/> โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)</td></tr><tr><td><input type="radio"/> Healthy Families A & B</td><td><input type="radio"/> โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSLP)</td></tr><tr><td><input type="radio"/> โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC)</td><td><input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA)</td></tr><tr><td><input type="radio"/> CalWORKs (TANF) หรือ Tribal TANF</td><td><input type="radio"/> Head Start Income Eligible เฉพาะชนเผ่า</td></tr><tr><td><input type="radio"/> CalFresh / SNAP (แสดมปีอาหาร)</td><td></td></tr></table> <p><input type="radio"/> NO</p> <p>รายได้ต่อปีของครัวเรือนของท่านคือเท่าไร? (รวมสมาชิกในครัวเรือนทุกคนก่อนหักลดหย่อนภาษี) ▼</p> <p><input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140</p> <p><input type="radio"/> หากรายได้ของท่านมากกว่า \$55,140 โปรดระบุจำนวนรายได้ที่: \$ <input type="text"/>.<input type="text"/> ต่อปี</p> <p>กรณารับแหล่งรายได้: ▼</p> <table border="0"><tr><td><input type="radio"/> เงินประกันสังคม</td><td><input type="radio"/> ค่าจ้าง และ/หรือ</td><td><input type="radio"/> เงินช่วยเหลือคู่สมรสหรือบุตร</td></tr><tr><td><input type="radio"/> SSP หรือ SSDI</td><td><input type="radio"/> กำไรจากอาชีพอิสระ</td><td><input type="radio"/> ทุน, เงินสนับสนุน,</td></tr><tr><td><input type="radio"/> เงินบำนาญ</td><td><input type="radio"/> สิทธิผลประโยชน์จากการว่างงาน</td><td><input type="radio"/> หรือเงินช่วยเหลืออื่นๆ</td></tr><tr><td><input type="radio"/> ดอกเบี้ยเงินฝาก หรือเงินปันผล:</td><td><input type="radio"/> เงินประกันหรือเงินที่ได้จากการตกลง</td><td><input type="radio"/> ที่ใช้ในการ</td></tr><tr><td><input type="radio"/> บัญชีออมทรัพย์, หุ้น, พันธบัตร,</td><td><input type="radio"/> งยอมคืดความ</td><td><input type="radio"/> ครองชีพ</td></tr><tr><td><input type="radio"/> หรือบัญชีสำหรับผู้เกษียณ</td><td><input type="radio"/> เงินชดเชยทุพพลภาพ</td><td><input type="radio"/> ค่าเช่าหรือรายได้จากค่าลิขสิทธิ์</td></tr><tr><td></td><td><input type="radio"/> หรือเงินชดเชยแรงงาน</td><td><input type="radio"/> เงินสด หรือรายได้อื่นๆ</td></tr></table>	<input type="radio"/> Medi-Cal / Medicaid: อายุน้อยกว่า 65 ปี	<input type="radio"/> โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP)	<input type="radio"/> Medi-Cal / Medicaid: อายุ 65 ปีขึ้นไป	<input type="radio"/> โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)	<input type="radio"/> Healthy Families A & B	<input type="radio"/> โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSLP)	<input type="radio"/> โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC)	<input type="radio"/> Bureau of Indian Affairs General Assistance (BIA GA)	<input type="radio"/> CalWORKs (TANF) หรือ Tribal TANF	<input type="radio"/> Head Start Income Eligible เฉพาะชนเผ่า	<input type="radio"/> CalFresh / SNAP (แสดมปีอาหาร)		<input type="radio"/> เงินประกันสังคม	<input type="radio"/> ค่าจ้าง และ/หรือ	<input type="radio"/> เงินช่วยเหลือคู่สมรสหรือบุตร	<input type="radio"/> SSP หรือ SSDI	<input type="radio"/> กำไรจากอาชีพอิสระ	<input type="radio"/> ทุน, เงินสนับสนุน,	<input type="radio"/> เงินบำนาญ	<input type="radio"/> สิทธิผลประโยชน์จากการว่างงาน	<input type="radio"/> หรือเงินช่วยเหลืออื่นๆ	<input type="radio"/> ดอกเบี้ยเงินฝาก หรือเงินปันผล:	<input type="radio"/> เงินประกันหรือเงินที่ได้จากการตกลง	<input type="radio"/> ที่ใช้ในการ	<input type="radio"/> บัญชีออมทรัพย์, หุ้น, พันธบัตร,	<input type="radio"/> งยอมคืดความ	<input type="radio"/> ครองชีพ	<input type="radio"/> หรือบัญชีสำหรับผู้เกษียณ	<input type="radio"/> เงินชดเชยทุพพลภาพ	<input type="radio"/> ค่าเช่าหรือรายได้จากค่าลิขสิทธิ์		<input type="radio"/> หรือเงินชดเชยแรงงาน	<input type="radio"/> เงินสด หรือรายได้อื่นๆ
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<input type="radio"/> เงินประกันสังคม	<input type="radio"/> ค่าจ้าง และ/หรือ	<input type="radio"/> เงินช่วยเหลือคู่สมรสหรือบุตร																																
<input type="radio"/> SSP หรือ SSDI	<input type="radio"/> กำไรจากอาชีพอิสระ	<input type="radio"/> ทุน, เงินสนับสนุน,																																
<input type="radio"/> เงินบำนาญ	<input type="radio"/> สิทธิผลประโยชน์จากการว่างงาน	<input type="radio"/> หรือเงินช่วยเหลืออื่นๆ																																
<input type="radio"/> ดอกเบี้ยเงินฝาก หรือเงินปันผล:	<input type="radio"/> เงินประกันหรือเงินที่ได้จากการตกลง	<input type="radio"/> ที่ใช้ในการ																																
<input type="radio"/> บัญชีออมทรัพย์, หุ้น, พันธบัตร,	<input type="radio"/> งยอมคืดความ	<input type="radio"/> ครองชีพ																																
<input type="radio"/> หรือบัญชีสำหรับผู้เกษียณ	<input type="radio"/> เงินชดเชยทุพพลภาพ	<input type="radio"/> ค่าเช่าหรือรายได้จากค่าลิขสิทธิ์																																
	<input type="radio"/> หรือเงินชดเชยแรงงาน	<input type="radio"/> เงินสด หรือรายได้อื่นๆ																																
3	<p>ท่านเห็นด้วยกับข้อความต่อไปนี้หรือไม่? กรุณาอ่านและลงนามด้านล่าง</p> <p>ข้าพเจ้ารับรองว่าข้อมูลที่ข้าพเจ้าระบุในเอกสารใบสมัครฉบับนี้ถูกต้องและเป็นความจริง หากมีการร้องขอ ข้าพเจ้ายินยอมที่จะแสดงหลักฐานที่แสดงว่าข้าพเจ้ามีสิทธิ์เข้าร่วมโครงการ CARE ข้าพเจ้าตกลงจะแจ้ง The Gas Company ทันทีที่ข้าพเจ้าขาดสถานะภาพในการได้รับส่วนลดจากโครงการ ข้าพเจ้าตกลงว่า หากข้าพเจ้าได้รับส่วนลดโดยที่ข้าพเจ้าไม่ผ่านเกณฑ์ในการเข้าร่วมโครงการ ข้าพเจ้าอาจต้องจ่ายคืนส่วนลดที่ข้าพเจ้าได้รับ ข้าพเจ้าตกลงว่า The Gas Company สามารถเปิดเผยข้อมูลของข้าพเจ้ากับเจ้าหน้าที่หรือบริษัทสาธารณูปโภคอื่นๆ เพื่อลงทะเบียนข้าพเจ้าในโครงการช่วยเหลืออื่นๆ ได้</p> <p>ลายเซ็น: X วันที่: <input type="text"/> / <input type="text"/> / <input type="text"/></p>																																	

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Individually Metered Residential (Form 6674-D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)
ADVICE LETTER NO. 4572
DECISION NO.

ISSUED BY
Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)
DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



YOUR RATE DISCOUNT IS EXPIRING



Dear Customer:

Date:

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

1. Return the completed and signed form by mail or fax,
- 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.

HOW TO QUALIFY FOR THE CARE DISCOUNT:

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

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective January 1, 2014 to May 31, 2014)</i> <small>*current household income from all sources before deductions</small>	
Number of Persons in Household	Total Annual Income
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each additional person	+\$8,040

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)
 FAX: (213) 244-4665

Account Number:



CARE 20% Rate Discount Recertification Form

Form 6674-D EN (01/14)

Please use DARK ink and print clearly to ensure proper processing

Correct way to mark circles: ●

CARE PROGRAM, ML GT19A1

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) ▼

- Medi-Cal / Medicaid: Under Age 65
- Medi-Cal / Medicaid: 65 or older
- Healthy Families Categories A & B
- Women, Infants, and Children Program (WIC)
- CalWORKs (TANF) or Tribal TANF
- CalFresh / SNAP (Food Stamps)
- 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

What is your yearly household income (before deductions, including all members of the household)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

If more than \$55,140, 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: ____ / ____ / ____

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

Apreciable cliente:

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 métodos que se enumeran a continuación:

1. Devuelva el Formulario de Recertificación debidamente llenado y firmado por correo o fax,
○
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.

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)
CalWORKs (TANF) o TANF Tribal
CalFresh / SNAP (Estampillas para Comida)
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 enero de 2014 al 31 de mayo de 2014)</i> *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Cada persona adicional	+\$8,040

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)

FAX: (213) 244-4665

Número de cuenta:



A Sempra Energy utility®

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

Form 6674-D SP (01/14)

CARE PROGRAM, ML GT19A1
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: () - -

Correo electrónico: _____

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

2

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

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

Sí (Si su respuesta es afirmativa, marque el(los) programa(s) de participación) ▼

<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"/> CalWORKs (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal
<input type="radio"/> CalFresh / SNAP (Estampillas para Comida)	

No

¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Si es más de \$55,140, 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 : ____ / ____ / ____



A Sempra Energy utility®

**您的費率折扣
即將過期**

親愛的客戶：

日期：

您現在正通過 The Gas Company 的加州能源優惠 (CARE) 計劃，享受占每月瓦斯（煤氣）帳單 20% 的 CARE 折扣優惠。若要繼續享有 CARE 計劃的折扣，您需要在 90 天內再認證您仍符合資格。您可以使用下列方法之一來重新認證您的資格：

1. 填寫好並在重新認證表格 (Re-certification Form) 上簽名，用所提供的信封寄回或傳真。

或者

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

或者

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

符合 CARE 折扣的這些種資格：

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)、CalWORKs (TANF)、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)、CalFresh / SNAP (食物券)、National School Lunch Program (NSLP, 全國學童免費午餐計劃)、Low Income Home Energy Assistance Program (LIHEAP, 低收入家庭能源協助計劃)、Supplemental Security Income (SSI, 社會安全補助金)

或者

家庭收入最高限額*： (有效期 2014 年 1 月 1 日至 2014 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	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
每多一位家庭成員	+\$8,040

參加條件

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

若需更多關於 CARE 計劃的資訊，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)

傳真(FAX)：(213) 244-4665

賬戶號碼：



CARE 20% 費率折扣資格重新認證表格

Form 6674-D CH (01/14)

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: ●

CARE PROGRAM ML GT19A1
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) ▼

<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"/> CalWORKs (TANF)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"/> CalFresh / SNAP (食物券)	

否

請按照您的家庭年收入 (稅前收入, 包括所有家庭成員), 把適當項目的圓圈塗黑: ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

如果多於 \$55,140, 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: / /



A Sempra Energy utility®

귀하의 요금 할인이
종료됩니다

친애하는 고객님:

날짜:

귀하께서는 현재 The Gas Company의 캘리포니아 에너지 대체 요금 (CARE) 프로그램을 통하여 월별 가스 요금에 대해 20% 할인을 받고 계십니다. CARE 할인을 계속 받으시려면, 90일 내에 수혜 자격을 갱신하셔야 합니다. 아래에 나열된 3 방법 중 하나를 사용하여 갱신을 하실 수 있습니다.

1. 제공된 봉투를 사용하여 작성하고 서명한 증명 양식을 택배나 팩스로 제출합니다.

또는

1. 전화번호 1-866-716-3452에 연중 무휴로 하루 24시간 아무 때나 전화하여 재증명 지시에 따르십시오. 좌번호를 준비하십시오. 귀하의 구좌번호는 이 페이지 맨 아래에 있습니다.

또는

2. 구좌 번호를 갖추고 저의 웹사이트 www.socalgas.com/care/recert/를 방문하여 갱신에 임하실 수 있습니다.

CARE 할인 수혜 자격을 충족시키는 가지 방법이 있습니다:

공공 지원 프로그램:
귀하나 가족일원이 다음 프로그램으로부터 혜택을 받는 경우: 메디케이드 (Medicaid / Medi-Cal), 건강한 가족 유형 A 및 B (Healthy Families A&B), 여성, 유아 및 어린이 (WIC), CalWORKs (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), CalFresh / SNAP (푸드 스탬프), 학교 점심 프로그램 (National School Lunch Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)

또는

최대 가구 소득*: (2014. 1. 1 부터 2014. 5. 31 까지 유효) *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
각 추가 사용자	+\$8,040

참여 조건

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

CARE에 대한 사항은 아래의 THE GAS COMPANY 번호로 문의하십시오:

영어: 1-800-427-2200

북경어: 1-800-427-1429

스페인어: 1-800-342-4545

한국어: 1-800-427-0471

광동어: 1-800-427-1420

월남어: 1-800-427-0478

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

팩스 (FAX): (213) 244-4665

구좌 번호:



CARE 20% 요금 할인 재증명 양식

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

Form 6674-D KO (01/14)

CARE PROGRAM ML GT19A1
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 질문으로 가십시오.) ▼

- | | |
|--|--|
| <input type="radio"/> Medi-Cal / 메디케어(Medicaid): 65 세 미만 | <input type="radio"/> 저소득자 주택 에너지 지원 프로그램인 (LIHEAP) |
| <input type="radio"/> Medi-Cal / 메디케어(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 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"/> CalWORKs (TANF) 또는 인디언 부족 TANF | <input type="radio"/> 헤드 스타트 소득 자격(Head Start Income Eligible) (인디언 부족만 해당) |
| <input type="radio"/> CalFresh / SNAP (푸드 스탬) | |

아니오

귀하의 연간 소득은 얼마입니까 (공제전, 모든 가족의 소득 포함)? ▶

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

\$55,140 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: / /



A Sempra Energy utility®

CHƯƠNG TRÌNH GIẢM GIÁ CỦA QUÝ VỊ SẮP HẾT HẠN

Kính Gởi Quý Khách Hàng:

Ngày:

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

1. Gởi trả Mẫu Giấy Chứng Nhận được ký tên và điền đầy đủ trong phong bì cung cấp sẵn qua đường bưu điện hoặc fax.

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.

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),
CalWORKs (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,
CalFresh / SNAP (Trợ Cấp Phiếu Thực Phẩm),
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

LỢI TỨC TỐI ĐA CỦA HỘ GIA ĐÌNH*: <i>(hiệu lực từ ngày 1 tháng một, 2014 đến 31 tháng Năm, 2014)</i> <i>*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình</i>	
Số Người trong Gia Đình	Tổng Lợi Tức Hàng Năm
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Mỗi người bổ sung	+\$8,040

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)
 FAX: (213) 244-4665

Số Trương Mục:



Sempra Energy utility®

Xin Giảm Giá 20% Theo Chương Trình CARE

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

Bôi đen đúng cách: ●

Form 6674-D VI (01/14)

CARE PROGRAM ML GT19A1 PO
BOX 3249
LOS ANGELES, CA 90051-1249

1

Tên Khách Hàng:

Địa chỉ:

Số Trương Mục:

Điện Thoại Nhà #: () - -

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)▼

- | | |
|---|---|
| <input type="radio"/> Medi-Cal/Medicaid: Dưới 65 tuổi | <input type="radio"/> Trợ Giúp Năng Lượng Tại Gia Cho Người Lợi Tức Thấp (LIHEAP) |
| <input type="radio"/> Medi-Cal/Medicaid: 65 tuổi hoặc hơn | <input type="radio"/> Trợ Cấp An Sinh (SSI) |
| <input type="radio"/> Gia Đình Khỏe Mạnh Loại A & B | <input type="radio"/> Chương Trình Toàn Quốc Ăn Trưa Tại Trường (NSLP) |
| <input type="radio"/> Chương Trình Phụ Nữ Sơ Sinh và Trẻ Em (WIC) | <input type="radio"/> Bureau of Indian Affairs General Assistance |
| <input type="radio"/> CalWORKs (TANF) hoặc TANF Bản Địa | <input type="radio"/> Đủ điều kiện lợi tức cho Head Start (Bản Địa mà thôi) |
| <input type="radio"/> CalFresh / SNAP (Trợ Cấp Phiếu Thực Phẩm) | |

KHÔNG

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 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Nếu nhiều hơn \$55,140, xin điền tổng số vào đây \$.00 mỗi năm

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

- | | | |
|---|---|---|
| <input type="radio"/> An sinh Xã hội | <input type="radio"/> Lương và/hoặc Lợi tức Việc Làm Tự do | <input type="radio"/> Cấp dưỡng nuôi Con hoặc Phôi nẫu |
| <input type="radio"/> SSP, SSDI | <input type="radio"/> Trợ cấp Thất nghiệp | <input type="radio"/> Học bổng, tài trợ giáo dục hay trợ giúp khác dùng để trang trải chi phí sinh sống |
| <input type="radio"/> Hưu bổng | <input type="radio"/> Bồi thường Bảo hiểm hoặc Thỏa Hiệp Pháp Định | <input type="radio"/> Lợi tức cho Thuê hoặc Tiền Bản quyền |
| <input type="radio"/> Tiền Lờ hay Cổ tức từ: Trương mục Tiết kiệm, Cổ Phiếu, Trái Phiếu, hay Trương mục Hưu trí | <input type="radio"/> Lãnh tiền Bệnh hoặc Bồi thường Thương tích tại Sở làm | <input type="radio"/> 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 cứ 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 6491-2D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H10

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



A Sempra Energy utility®

20 PERCENT DISCOUNT CARE APPLICATION

Southern California Gas Company's (SoCalGas®) California Alternate Rates for Energy (CARE) program provides a 20 percent 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 SoCalGas.

Please complete the application and return it in the envelope provided or apply online at socialgas.com (search "CARE").

HOW TO QUALIFY FOR THE CARE DISCOUNT

PUBLIC ASSISTANCE PROGRAMS:

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

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



MAXIMUM HOUSEHOLD INCOME:

(effective January 1, 2014 to May 31, 2014)

Number of Persons in Household	Total Annual Income*
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260

For each additional household member, add \$8,040

* 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 SoCalGas 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:

Energy Savings Assistance Program: Offers no-cost energy saving home improvements. 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: Provides 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



CARE 20 PERCENT RATE DISCOUNT APPLICATION

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



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: - -

EMAIL 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) ▼

- Medi-Cal/Medicaid: Under Age 65
- Medi-Cal/Medicaid: 65 or older
- Healthy Families Categories A & B
- Women, Infants, and Children Program (WIC)
- CalWORKs (TANF) or Tribal TANF
- CalFresh/SNAP (Food Stamps)
- 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 ▼

What is your yearly household income (before deductions, including all members of the household) ▼

- \$0 - \$22,980
- \$22,981 - \$31,020
- \$31,021 - \$39,060
- \$39,061 - \$47,100
- \$47,101 - \$55,140
- If more than \$55,140, enter the dollar amount here: \$, .00 per year

Please mark your sources of income: ▼

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

3

Declaration: Please read and sign below.

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



El programa de Tarifas Alternas para Energía en California (CARE) de Southern California Gas Company's (SoCalGas®) ofrece un descuento del 20 por ciento 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 SoCalGas.

Sírvase llenar el formulario de solicitud y regresarlo en el sobre provisto, o presentarlo en línea en socialgas.com/espanol (busque la palabra clave "CARE").

CÓMO CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:	INGRESO MÁXIMO EN EL HOGAR:	
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:	(en vigor del 1 de enero de 2014 al 31 de mayo de 2014)	
	Número de personas en el hogar	Ingreso total anual*
Medi-Cal/Medicaid	1	\$31,020
Healthy Families Categories A & B	2	\$31,020
Programa de mujeres, infantes y niños (WIC)	3	\$39,060
CalWORKs (TANF) o TANF tribal	4	\$47,100
Elegible para ingreso de Ventaja Inicial - Solamente tribal	5	\$55,140
Agencia de Asuntos Indios, Asistencia General (BIA GA)	6	\$63,180
CalFresh/SNAP (Food Stamps/ Estampillas para comida)	7	\$71,220
National School Lunch Program (NSLP)	8	\$79,260
Programa de Asistencia con la Energía Doméstica para Hogares de Bajos Ingresos (LIHEAP)	Por cada miembro adicional en el hogar, añade \$8,040	
Ingreso Suplementario del Seguro Social (SSI)	* 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 SoCalGas 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:

Energy Savings Assistance Program: Ofrece mejoras sin costo que ahorran energía. Para más información, llame al 1-800-331-7593.



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

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: Ofrece 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 POR CIENTO DE DESCUENTO

Para tener derecho al 20 por ciento de descuento en la tarifa de gas de su factura, por favor llene el formulario de solicitud y regréselo a SoCalGas. Recibirá su descuento una vez que su solicitud llena y firmada sea aprobada por SoCalGas.



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) ▼

- 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)
- CalWORKs (TANF) o TANF Tribal
- CalFresh/SNAP (Food Stamps/Estampillas para comida)
- 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 ▼

¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

- \$0 - \$22,980
- \$22,981 - \$31,020
- \$31,021 - \$39,060
- \$39,061 - \$47,100
- \$47,101 - \$55,140

Si es más de \$55,140, 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 SoCalGas 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 SoCalGas puede compartir mis datos con otras empresas de servicios públicos o agentes para inscribirme en sus programas de asistencia.

FIRMA: X

FECHA: / /

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Submetered Residential (Form 6677-D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H12

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



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 by mail or fax. 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 socalgas.com (Search "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 or Medi-Cal
Healthy Families A&B
Women, Infants, & Children (WIC)
CalWORKs (TANF) or Tribal TANF
Head Start Income Eligible - Tribal Only
Bureau of Indian Affairs General Assistance
CalFresh / SNAP (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective January 1, 2014 to May 31, 2014)</i>	
*current household income from all sources before deductions	
Number of Persons in Household	Total Annual Income
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each additional person	+\$8,040

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:

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



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

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

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

FOR 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)
 Fax: (213) 244-4665



CARE 20% Rate Discount Application

Form 6677-D EN (01/14)

Please use DARK ink and print clearly to ensure proper processing

CARE PROGRAM, ML GT19A1

PO BOX 3249

LOS ANGELES, CA 90051-1249

Correct way to mark circles: ●



1

Tenant Name (as it appears on your bill):	
Home Address (street, space #, city, zip):	
Facility ID:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Phone Number:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
E-mail Address:	<input type="text"/>

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) ▼

<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"/> CalWORKs (TANF) or Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Only
<input type="radio"/> CalFresh / SNAP (Food Stamps)	

NO

What is your yearly household income (before deductions, including all members of the household)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

If more than \$55,140, enter amount here: \$,. 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: / /

**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. Por favor, complete y envíe la solicitud por correo o fax. 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 visite socialgas.com/español (busque la palabra clave "CARE").

CÓMO CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:	INGRESO MÁXIMO EN EL HOGAR: <i>(en vigor del 1 de enero de 2014 al 31 de mayo de 2014)</i> *ingreso actual en el hogar de todas las fuentes antes de deducciones	
<p>Si usted o alguien que vive en su hogar participa en cualquiera de estos programas:</p> <p>Medicaid / Medi-Cal Healthy Families Categorías A & B Programa para Mujeres, Infantes, y Niños (WIC) CalWORKs (TANF) o TANF Tribal CalFresh / SNAP (Estampillas para Comida) 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</p>	Número de personas en el hogar	Ingreso total anual
	1	\$31,020
	2	\$31,020
	3	\$39,060
	4	\$47,100
	5	\$55,140
	6	\$63,180
	7	\$71,220
	8	\$79,260
	Cada persona adicional	+\$8,040

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:

Energy Savings Assistance Program: 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 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)
Fax: (213) 244-4665




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

Form 6677-D SP (01/14)

CARE PROGRAM, ML GT19A1
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 inquilino (tal como aparece en su factura):	
	Domicilio:	
	Facility ID/ Número de complejo habitacional:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Teléfono:	(<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Correo electrónico:	<input type="text"/>

2	 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"/>												
<u>¿Está usted (o alguien que vive en su hogar) inscrito en alguno de los siguientes programas de asistencia?</u>													
<input type="radio"/> Sí (Si su respuesta es afirmativa, marque el(los) programa(s) de participación) ▼													
<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"/> CalWORKs (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"/> CalFresh / SNAP (Estampillas para Comida)</td> <td></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"/> CalWORKs (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal	<input type="radio"/> CalFresh / SNAP (Estampillas para Comida)	
<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"/> CalWORKs (TANF) o TANF Tribal	<input type="radio"/> Asistencia General Elegible para Ingreso de Ventaja Inicial - solamente tribal												
<input type="radio"/> CalFresh / SNAP (Estampillas para Comida)													
<input type="radio"/> No													
¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼													
<input type="radio"/> \$0 - \$22,980 <input type="radio"/> \$22,981 - \$31,020 <input type="radio"/> \$31,021 - \$39,060 <input type="radio"/> \$39,061 - \$47,100 <input type="radio"/> \$47,101 - \$55,140													
<input type="radio"/> Si es más de \$55,140, escriba el monto aquí : \$ <input type="text"/> , <input type="text"/> .00 al año													
Por favor marque sus fuentes de ingreso: ▼													
<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"/> 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
<input type="radio"/> Seguro Social	<input type="radio"/> Salarios y/o ingresos de autoempleo	<input type="radio"/> Pensión conyugal o alimenticia											
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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: <input checked="" type="checkbox"/> <input type="text"/> Fecha : <input type="text"/> / <input type="text"/> / <input type="text"/>

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Submetered Residential (Form 6678-D, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H12

ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____



YOUR RATE DISCOUNT IS EXPIRING

A Sempra Energy utility®

Dear Tenant:

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 the methods listed below:

1. Return your completed and signed by mail or fax,
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 facility ID at the bottom of this page,
OR
3. Visit our Website <http://www.socalgas.com/care/recert/> and have your facility ID ready.

HOW TO QUALIFY FOR THE CARE DISCOUNT:

PUBLIC ASSISTANCE PROGRAMS:
If you or someone in your household participates in any of these programs:
<ul style="list-style-type: none"> Medicaid or Medi-Cal Healthy Families A&B Women, Infants, & Children (WIC) CalWORKs (TANF) or Tribal TANF Head Start Income Eligible - Tribal Only Bureau of Indian Affairs General Assistance CalFresh / SNAP (Food Stamps) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*: <i>(effective January 1, 2014 to May 31, 2014)</i>	
<small>*current household income from all sources before deductions</small>	
Number of Persons in Household	Total Annual Income
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Each Additional Person	+\$8,040

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)
 FAX: (213) 244-4665

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-D EN (01/14)

CARE PROGRAM, ML GT19A1
 PO BOX 3249
 LOS ANGELES, CA 90051-1249



1

Tenant 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) ▼

<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"/> CalWORKs (TANF) or Tribal TANF	<input type="radio"/> Head Start Income Eligible - Tribal Only
<input type="radio"/> CalFresh / SNAP (Food Stamps)	

NO

What is your yearly household income (before deductions, including all members of the household)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

If more than \$55,140, 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: ____ / ____ / ____

EL DESCUENTO EN SU TARIFA ESTÁ POR VENCER



A Sempra Energy utility®

Apreciable inquilino:

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 métodos que se enumeran a continuación:

1. Devuelva el Formulario de Recertificación debidamente llenado y firmado por correo o fax,

○
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 complejo habitacional (*Facility ID*). Puede localizar su número de complejo habitacional en la parte inferior de esta página,

○
3. Visite nuestro sitio web www.socalgas.com/care/recert/ y tenga listo el número de complejo habitacional (*Facility ID*).

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) CalWORKs (TANF) o TANF Tribal CalFresh / SNAP (Estampillas para Comida) 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 enero de 2014 al 31 de mayo de 2014)</i> *ingreso actual en el hogar de todas las fuentes antes de deducciones	
Número de personas en el hogar	Ingreso total anual
1	\$31,020
2	\$31,020
3	\$39,060
4	\$47,100
5	\$55,140
6	\$63,180
7	\$71,220
8	\$79,260
Cada personal adicional	+\$8,040

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)
FAX: (213) 244-4665

Número de complejo habitacional (*Facility ID*):



A Sempra Energy utility®

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

Form 6678-D SP (01/14)

CARE PROGRAM, ML GT19A1
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 inquilino
(tal como aparece en su factura):

Domicilio:

Número de complejo
habitacional:

Teléfono: () - -

Correo electrónico:

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

2



**Número total de
adultos y niños que
viven en su hogar:**

1 2 3 4 5 6 si más de 6:

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

Sí (Si su respuesta es afirmativa, marque el(los) programa(s) de participación) ▼

- 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)
- CalWORKs (TANF) o TANF Tribal
- CalFresh / SNAP (Estampillas para Comida)
- 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

¿Cuál es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos los miembros del hogar)? ▼

\$0 - \$22,980 \$22,981 - \$31,020 \$31,021 - \$39,060 \$39,061 - \$47,100 \$47,101 - \$55,140

Si es más de \$55,140, 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 : / /

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM - BILL INSERT
(Form 6491-BI, 01/14)

T

(See Attached Form)

(TO BE INSERTED BY UTILITY)

ADVICE LETTER NO. 4572
DECISION NO.

1H10

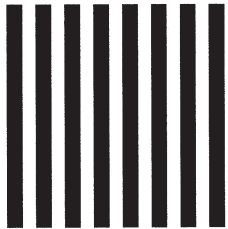
ISSUED BY

Lee Schavrien
Senior Vice President

(TO BE INSERTED BY CAL. PUC)

DATE FILED Nov 27, 2013
EFFECTIVE Jan 1, 2014
RESOLUTION NO. _____

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 GT19A1
SOUTHERN CALIFORNIA GAS COMPANY
PO BOX 515005
LOS ANGELES CA 90099-9316**



A Sempra Energy utility®

SAVE 20 Percent

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 PERCENT DISCOUNT
APPLICATION INSIDE OR APPLY AT
SOCALGAS.COM (SEARCH "ASSISTANCE")

Tarifas Alternas para Energía en California (CARE)

DESCUENTO DEL 20 POR CIENTO
EN SU TARIFA DE GAS NATURAL
SOLICITUD ADENTRO O APLIQUE EN

SOCALGAS.COM/ESPAÑOL
(BUSQUE LA PALABRA CLAVE "ASISTENCIA")

Dear Customer:

You may be eligible for a 20 percent 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 Southern California Gas Company (SoCalGas®). 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 SoCalGas. If you have any questions about the CARE program, or need assistance filling out the form, please visit socialgas.com (search "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 por ciento 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 SoCalGas. Por favor revise las calificaciones del programa en la solicitud. Si piensa que califica, complete y firme la solicitud y envíela a SoCalGas. Recibirá su(s) descuentos(s) una vez que su solicitud sea aprobada por SoCalGas. Si tiene alguna duda acerca de la solicitud, visite socialgas.com/espanol (busque la palabra clave "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 Southern California 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:

Energy Savings Assistance Program Energy Savings Assistance Program: Offers no-cost energy-saving home improvements.

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:

El Programa Energy Savings Assistance Program: Ofrece mejoras sin costo que ahorran energía. Para más información, por favor llame al 1-800-331-7593.

Asignación Médica Inicial (Medical Baseline): Provee asignación adicional de gas a una tarifa menor a los clientes con ciertas afecciones 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.



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(Continued)

(TO BE INSERTED BY UTILITY)
 ADVICE LETTER NO. 4572
 DECISION NO.

ISSUED BY
Lee Schavrien
 Senior Vice President

(TO BE INSERTED BY CAL. PUC)
 DATE FILED Nov 27, 2013
 EFFECTIVE Jan 1, 2014
 RESOLUTION NO. _____

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(Continued)

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(Continued)

(TO BE INSERTED BY UTILITY)
 ADVICE LETTER NO. 4572
 DECISION NO.

ISSUED BY
Lee Schavrien
 Senior Vice President

(TO BE INSERTED BY CAL. PUC)
 DATE FILED Nov 27, 2013
 EFFECTIVE Jan 1, 2014
 RESOLUTION NO. _____

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