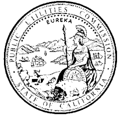
STATE OF CALIFORNIA Edmund G. Brown Jr., *Governor*

PUBLIC UTILITIES COMMISSION
505 VAN NESS AVENUE
SAN FRANCISCO, CA 94102-3298



May 30, 2014

Advice Letter 4639-G

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

Subject: Revision of the Income-Eligibility Guidelines for the CARE Program and Related Application Instruction and Forms

Dear Ms. Prince:

Advice Letter 4639-G is effective June 1, 2014.

Sincerely,

Edward F. Randolph, Director
Energy Division

Rasha Prince
Director
Regulatory Affairs

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

April 30, 2014

Advice No. 4639
(U 904 G)

Public Utilities Commission of the State of California

Subject: Revision of the Income-Eligibility Guidelines for the CARE Program and Related Application Instructions and Forms

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 A.

Purpose

This filing revises SoCalGas' Schedule No. G-CARE and application instructions and forms to reflect the increased income-eligibility guidelines and approved updated list of the categorical programs used to qualify individuals or households for the CARE program. This filing is made in compliance with Public Utilities (PU) Code Section 739.1(b)(1)[1] and Ordering Paragraph (OP) 3 of Resolution (Res.) E-3524, adopted February 19, 1998.[2]

Background

The Energy Division (ED) determined that, pursuant to Res. E-3524 and to the requirements of PU Code Section 739.1(b)(1), effective beginning with the 2012-2013 income guidelines update, it would use the Federal Poverty Guideline values and corresponding household

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[1] PU Code Section 739.1(b)(1) states: The Commission shall establish a program of assistance to low-income electric and gas customers with annual household incomes that are no greater than 200 percent of the federal poverty guideline levels, the cost of which shall not be borne solely by any single class of customer. The program shall be referred to as the California Alternate Rates for Energy or CARE program. The Commission shall ensure that the level of discount for low-income electric and gas customers correctly reflects the level of need.

[2] Res. E-3524 authorizes the energy utilities to change the income-eligibility guidelines for the CARE program pursuant to a communication issued by the Director of the Energy Division by May 1st of each year, with tariff revisions to be filed and become effective June 1st of each year.

size to determine and update the annual CARE and Energy Savings Assistance (ESA) Programs' income limits in its income guidelines letter.

Pursuant to Assembly Bill (AB) 327 and as approved in SoCalGas' Advice No. (AL) 4572, the income limits for households with 1-2 persons for CARE are no longer listed separately, but are consolidated. Income limits are otherwise displayed separately for household sizes of 3-8 persons.

Pursuant to the letter dated April 1, 2014 from the Director of the ED, SoCalGas was provided with the new CARE and ESA Programs' income-eligibility levels to be effective from June 1, 2014 through May 31, 2015, as follows:[3]

Household Size	***Income Eligibility Upper Limit***
1 - 2	*$31,460*
3	*$39,580*
4	*$47,700*
5	*$55,820*
6	*$63,940*
7	*$72,060*
8	*$80,180*
Each Additional Person	*$8,120*

Appendix A of the letter also included the approved updated list of the categorical programs, as follows:

List of Categorical Eligible Programs
Bureau of Indian Affairs General Assistance
CalFresh/Supplemental Nutrition Assistance Program (SNAP)
CalWORKs/Temporary Assistance for Needy Families (TANF)
Head Start Income Eligible (Tribal Only)
Low-income Home Energy Assistance Program (LIHEAP)
Medicaid/Medi-Cal for Families A & B
National School Lunch Program (NSLP)
Supplemental Security Income (SSI)
Tribal TANF
Women, Infants, and Children Program (WIC)

[3] The ED letter, dated April 1, 2014, also clarifies that although AB 327 did not address the income eligibility guidelines for ESA, the Commission aligns thresholds for both CARE and the ESA Programs to minimize confusion and maximize efficiency. SDG&E filed a motion seeking clarification of the ESA Program's eligibility guidelines on behalf of SoCalGas and Southern California Edison on December 19, 2013 regarding alignment with the CARE guidelines. If that motion is not addressed prior to June 1, 2014, SoCalGas will implement the new guidelines as instructed by the ED letter in accordance with the effective date.

The letter further directs the energy utilities to file revised tariffs with the ED reflecting the new income levels by May 1, 2014. Because the CARE application instructions and forms are part of the tariffs, revised versions are provided in Attachment A.

Tariff Revisions

This filing updates Schedule No. G-CARE and the CARE application instructions and forms to reflect the revised income-eligibility guidelines and approved updated list of the categorical programs, as follows:

Schedule Revisions
Schedule No. G-CARE

Application Form Revisions
Qualified Agricultural Employee Housing (Form 6632) - English
Qualified Non-Profit Group Living Facilities (Form 6571) - English
General Purpose, Direct Mail (Form 6491-DM) - English and Spanish
Individually Metered Residential Self Certification (Form 6491-E) - English, Spanish, Chinese, Korean, Vietnamese, Arabic, Armenian, Farsi, Hmong, Khmer, Russian, Tagalog, and Thai
Individually Metered Residential Self Recertification (Form 6674-E) - English, Spanish, Chinese, Korean, and Vietnamese
Capitation Program (Form 6491-2E) - English and Spanish
Individually Metered Residential Post-Enrollment Verification (Form 6675-E) - English, Spanish, Chinese, Korean, and Vietnamese
Sub-Metered Residential Post-Enrollment Verification (Form 6675-ES) - English and Spanish
Sub-Metered Residential Self-Certification (Form 6677-E) - English and Spanish
Sub-Metered Residential Self-Recertification (Form 6678-E) - English and Spanish
Bill Insert (Form 6491-BI) - English and Spanish

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 May 20, 2014. 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.

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. In compliance with OP 3 of Res. E-3524, adopted February 19, 1998; PU Code Section 739.1(b)(1), and the April 1, 2014 notice from the ED, the tariff sheets filed herein are to be effective for service on and after June 1, 2014.

Notice

A copy of this AL is being sent to SoCalGas' GO 96-B service list and the Commission's service lists in A.11-05-018, ESA Program, and R.08-07-011, Energy Efficiency Strategic Plan. Address change requests to the GO 96-B should be directed by electronic mail to tariffs@socalgas.com or call 213-244-3387. For changes to all other service lists, please contact the Commission's Process Office at 415-703-2021 or by electronic mail at Process_Office@cpuc.ca.gov.

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) #: 4639

Subject of AL: Revision of the Income-Eligibility Guidelines for the CARE Program and Related Application Instructions and Forms

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 AL[1]: N/A

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

Resolution Required? ☐ Yes ☒ No

Tier Designation: ☒ 1 ☐ 2 ☐ 3

Requested effective date: 6/1/14

No. of tariff sheets: 16

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 proposed[1]: 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. 4639

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 50293-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 2	Revised 49797-G
Revised 50294-G	Schedule No. G-CARE, CALIFORNIA ALTERNATE RATES FOR ENERGY (CARE) PROGRAM, Sheet 4	Revised 49798-G
Revised 50295-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY (CARE) PROGRAM FOR QUALIFIED , AGRICULTURAL EMPLOYEE HOUSING (Form 6632, 06/14)	Revised 49799-G
Revised 50296-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM FOR QUALIFIED NONPROFIT, GROUP LIVING FACILITIES (Form 6571, 06/14)	Revised 49800-G
Revised 50297-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - GENERAL PURPOSE, DIRECT MAIL (Form 6491-DM, 06/14)	Revised 49801-G
Revised 50298-G	SAMPLE FORMS: APPLICATIONS, Self-Certification CARE Application, Individually Metered Residential (Form 6491-E, 06/14)	Revised 49802-G
Revised 50299-G	SAMPLE FORMS: APPLICATIONS, Self-Recertification CARE Application, Individually Metered Residential (Form 6674-E, 06/14)	Revised 49803-G
Revised 50300-G	SAMPLE FORMS: APPLICATIONS, Capitation Program CARE Application, (Form 6491-2E, 06/14)	Revised 49804-G
Revised 50301-G	SAMPLE FORMS: APPLICATIONS, Post-Enrollment Verification CARE Application, Individually Metered Residential (Form 6675-E, 06/14)	Revised 49151-G
Revised 50302-G	SAMPLE FORMS: APPLICATIONS, Post-Enrollment Verification CARE Application, Sub-Metered Residential (Form 6675-ES, 06/14)	Revised 49152-G
Revised 50303-G	SAMPLE FORMS: APPLICATIONS, Self-Certification CARE Application, Submetered Residential (Form 6677-E, 06/14)	Revised 49805-G

ATTACHMENT A
Advice No. 4639

Cal. P.U.C. Sheet No.	Title of Sheet	Cancelling Cal. P.U.C. Sheet No.
Revised 50304-G	SAMPLE FORMS: APPLICATIONS, Self-Recertification CARE Application, Submetered Residential (Form 6678-E, 06/14)	Revised 49806-G
Revised 50305-G	APPLICATION FOR CALIFORNIA ALTERNATE RATES, FOR ENERGY PROGRAM - BILL INSERT, (Form 6491-BI, 06/14)	Revised 49807-G
Revised 50306-G	TABLE OF CONTENTS	Revised 50290-G
Revised 50307-G	TABLE OF CONTENTS	Revised 49809-G
Revised 50308-G	TABLE OF CONTENTS	Revised 50292-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:

Number of Persons In Household	Total Annual Household Income	
		D
1-2	$31,460	T,I
3	$39,580	I
4	$47,700	|
5	$55,820	|
6	$63,940	|
7	$72,060	|
8	$80,180	I

   For households with more than six persons, add $8,120 annually for each additional person living in the household. The above income levels are subject to change annually by the Commission. I

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

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)

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 $31,460. I

    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)

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY (CARE) PROGRAM FOR QUALIFIED
AGRICULTURAL EMPLOYEE HOUSING (Form 6632, 06/14) T

(See Attached Form)

A Sempra Energy utility®

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

INSTRUCTIONS

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

If another person in the household participates in any of these programs:

Medicaid or Medi-Cal
Medi-Cal for 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 (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2014 to May 31, 2015)
*current household income from all sources before deductions

Number of Persons in Household	Total Annual Income
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each Additional Person	+$8,120

- 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 Utility 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, 06/14) T

(See Attached Form)

Southern California Gas Company

A Sempra Energy utility

Glad to be of service.®

Application for California Alternate Rates For Energy (CARE) Program

For Qualified Nonprofit Group Living Facilities

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

INSTRUCTIONS

1. READ the information on page 2. If you have questions, call 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: **SoCalGas CARE Program**
   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.

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

A Sempra Energy utility

Glad to be of service.

Application for 20% Discount

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

Primary Facility Account Information:

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

Service Address | City | State

Mailing Address | City | State

Primary Contact

Phone | FAX

E-mail Address: | Account Number ☐☐☐☐☐☐☐☐☐☐ - ☐

Type of Facility:

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

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

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

Primary Services Offered by Facility:

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

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

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

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

All Qualified Satellite Facilities (if applicable):

Facility Name

Service Address

Account Number ☐☐☐☐☐☐☐☐☐☐ - ☐ | Satellite Facility? Yes ☐ No ☐

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

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

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

(Continued on Back)

Southern California Gas Company

A Sempra Energy utility®

Glad to be of service.®

Please complete the following information for all qualified satellite facilities:

Facility Name

Service Address

Account Number — Satellite Facility? Yes No

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

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

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

Facility Name

Service Address

Account Number — Satellite Facility? Yes No

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

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

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

Facility Name

Service Address

Account Number — Satellite Facility? Yes No

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

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

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

Certification of Eligibility:

Return to:

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 allowsSoCalGas 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 (SoCalGas®)
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 SoCalGas 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
Medi-Cal for 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 (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*
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each Additional Person	+ $8,120

**(effective June 1, 2014 to May 31, 2015)*

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, 06/14) T

(See Attached Form)

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 **socalgas.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
- Medi-Cal for 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 (Food Stamps)
- National School Lunch Program (NSLP)
- Low-Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

←OR→

MAXIMUM HOUSEHOLD INCOME:

(June 1, 2014 to May 31, 2015)

Number of Persons in Household	Total Annual Income*
1–2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
For each additional household member, add $8,120	

* 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 **socalgas.com** (search "*ASSISTANCE*") or call 1-800-427-2200.

Sincerely,
Ted Humphrey
CARE Program Sr. Market Advisor

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 **socalgas.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
- Medi-Cal para Familias A y B
- Programa para Mujeres, Bebés y Niños (WIC)
- CalWORKs (TANF) o TANF tribal
- Ingreso elegible para Head Start (tribal únicamente)
- Buró de Asistencia General para Asuntos de Nativos Americanos
- CalFresh (Estampillas para comida)
- Programa Nacional de Almuerzos Escolares (NSLP)
- Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- Ingreso Suplementario del Seguro Social (SSI)

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)

Número de personas en el hogar	Ingreso total anual*
1–2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Por cada miembro adicional en el hogar, añada $8,120	

* Incluye todas las fuentes de ingreso actual en el hogar 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 presentar su aplicacion nuevamente cuando se le solicite. **4)** Tiene que notificar a SoCalGas en un plazo no mayor de 30 días si deja de reunir los requisitos para participar en el programa. **5)** Tal vez se le pida que verifique su eligibilidad para el programa CARE.

SoCalGas tiene el compromiso de crear formas 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 **socalgas.com/espanol** (busque la palabra clave "*ASISTENCIA*") o llámenos al 1-800-342-4545.

Atentamente,
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.

HOME PHONE: ___ - ___ - ____

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

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, 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: __ / __ / __

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 9 4

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Printed on recycled paper with soy-based inks. FORM 6491-DM 0614 N14J0016B XK

SOLICITUD CARE PARA UN

20 Por Ciento de Descuento

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.

TELEFÓNO DE CASA: ☐☐☐ – ☐☐☐ – ☐☐☐☐

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
- ○ Medi-Cal para Familias A y B
- ○ Programa para Mujeres, Bebés y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa Nacional de Almuerzos Escolares (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **NO**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, escriba la suma anual: $☐☐,☐☐☐.00

Por favor marque sus fuentes de ingreso:

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

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

Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Si se me solicita, convengo en presentar comprobantes de que reúno los requisitos de CARE. Convengo en informar a 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: ☐☐/☐☐/☐☐

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 9 2

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Impreso en papel reciclado con tintas a base de soya. FORM 6491-DM 0614 N14J0016B XK

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Individually Metered Residential (Form 6491-E, 06/14) T

(See Attached Form)

Form 6491-E EN (06/14)

20% DISCOUNT CARE APPLICATION

Southern California Gas Company (SoCalGas®)'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 SoCalGas.

Please complete and return the application by mail, fax, 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
Medi-Cal for 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 (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2014 to May 31, 2015)
*current household income from all sources before deductions

Number of Persons in Household	Total Annual Income
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each Additional Person	+$8,120

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 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-E EN (06/14)

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:	

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

○ **NO**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, enter amount here: $, .00 per year

Please mark your sources of income: ▼

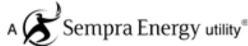
- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child 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 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**: / /



Form 6491-E SP (06/14)

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 Southern California Gas Company (SoCalGas®) 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 SoCalGas.

Por favor, complete y envie la solicitud por correo, fax, o visite socalgas.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
Medi-Cal Para Familias A & B
Programa para Mujeres, Bebés y Niños (WIC)
CalWORKs (TANF) o TANF Tribal
CalFresh (Estampillas para Comida)
Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa Nacional de Almuerzos Escolares (NSLP)
Buró de Asistencia General para Asuntos de Nativos Americanos
Ingreso elegible para Head Start (tribal únicamente)

o

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

Número de personas en el hogar	Ingreso total anual
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Cada personal adicional	+$8,120

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: 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-E SP (06/14)

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:	

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
- ○ Medi-Cal para familias A & B
- ○ Programa para Mujeres, Bebés y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para Comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI) National
- ○ School Lunch Program (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **No**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, 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 :** / /

Form 6491-E CH (06/14)

20% CARE折扣申請表

加州能源優惠計劃申請

Southern California Gas Company (SoCalGas®)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 SoCalGas 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:

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)、 Medi-Cal for 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(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, 社會安全輔助金)

或者

家庭收入最高限額*:
（有效期 2014年 6月 1日至 2015年 5月 31日）
*包括所有來源的家庭現有稅前收入

家庭成員人數	年收入總額
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
多一位家庭成員	+$8,120

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 SoCalGas。/ 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,緊急帳單協助和增强禦寒性能服務。請致電 California Dept. of Community Services and Development（加州社區服務與發展部）1-866-675-6623。

California Lifeline（加州普濟電話服務計劃）：提供電話費優惠給類似 CARE 收入標準的低收入消費者。若需更多訊息，請聯繫您的電話服務公司。

若需更多資訊，請致電我們的客戶服務：

英語：1-800-427-2200　國語：1-800-427-1429　西班牙語：1-800-342-4545
韓語：1-800-427-0471　粵語：1-800-427-1420　越南語：1-800-427-0478
聽覺障礙專綫 (TDD/TTY): 1-800-252-0259 （僅提供英語和西班牙語服務）
FAX: (213) 244-4665

A Sempra Energy utility®

CARE 20% 費率折扣申請表

請用深色筆以正楷填寫清晰以確保適當受理
正確涂圈方法：●

Form 6491-E CH (06/14)

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：( )-

E-mail：

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）*▼

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

○ 否

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ 如果多于 $63,940，請在此處填寫金額：$,.00 每年

請把您家庭收入所有來源前面的圓圈塗黑：▼

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

3

您同意以下聲明嗎？請您閱讀並簽字。
我願意證明上述申請資料正確屬實。若需要我也同意提供文件證明符合 CARE 的資格。我同意若我不再符合條件時，即通知 SoCalGas。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 SoCalGas可將有關我的資料提供給其它的公用事業公司和組織團體以協助我加入他們的協助計劃。

簽名：X 日期： / /

Form 6491-E KO (06/14)

20% CARE 할인 신청서

캘리포니아 에너지 대체 요금 신청서

Southern California Gas Company(SoCalGas®)의 캘리포니아 에너지 대체 요금(CARE) 프로그램은 적격 가구의 월별 가스 요금에 대해 20% 할인을 제공합니다. 자격을 갖추고 또한 가스 서비스를 새로 시작한 후 90 일 내에 승인을 받은 사람은 가스 개설료에 대해 $15 할인을 받습니다. 귀하의 작성되고 서명된 신청서를 SoCalGas에서 승인하면 할인이적용될 것입니다.

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 (Medi-Cal for 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 (푸드 스탬프), 학교 점심 프로그램 (National School Lunch Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)

또는

최대 가구 소득*: *(2014. 6. 1 부터 2015. 5. 31까지 유효)* *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
각 추가 사용자	+$8,120

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 SoCalGas에 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　　광동어: 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-E KO (06/14)

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

2

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

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

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

- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 미만
- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 이상
- ○ 가정 건강 유형 (Medi-Cal for families) A & B
- ○ 여성, 유아 및 어린이 프로그램(WIC)
- ○ CalWORKs (TANF) 또는 인디언 부족 TANF
- ○ CalFresh (푸드 스탬)
- ○ 저소득자 주택 에너지 지원 프로그램인 (LIHEAP)
- ○ 보조사회보장수입 (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 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ $63,940 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 SoCalGas 에 통보함에 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수 있다는 것을 본인은 이해합니다. SoCalGas 에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: X 날짜: / /

A Sempra Energy utility®

Form 6491-E VI (06/14)

ĐƠN XIN GIẢM GIÁ CARE 20%

ĐƠN XIN HƯỞNG MỨC GIÁ NĂNG LƯỢNG THAY THẾ CỦA CALIFORNIA

Chương Trình Mức Giá Năng Lượng Thay Thế California (California Alternate Rates for Energy hay CARE) của Southern California Gas Company (SoCalGas®) 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 SoCalGas 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,
Medi-Cal cho các gia đình 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 (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*:
(Có hiệu lực từ 1 tháng 6 năm 2014 đến ngày 31 tháng 5 2015)
*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình

Số Người trong Gia Đình	Tổng Lợi Tức Hàng Năm
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Mỗi người bổ sung	+$8,120

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 SoCalGas 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™

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

Form 6491-E VI (06/14)

Đơn Xin Giảm Giá 20% Theo Chương Trình CARE

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

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:

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)*▼

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

○ **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 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Nếu nhiều hơn $63,940, xin điền tổng số vào đây $, .00 mỗi năm

Xinbôi đe n vào vòng tròn của các nguồn lợi tức của quý vị: ▼

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

3

Quý vị có đồng ý với điều sau đây không? Xin đọc và ký bên dưới.

Tôi xin khai rõ rằng thông tin mà tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý sẽ cung cấp bằng cớ về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý báo cho SoCalGas 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 SoCalGas 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:** / /

Southern California Gas Company
A Sempra Energy utility®

Form 6491-E ARA (06/14)

طلب تخفيض
%20

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

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

كيف تتأهل للحصول على تخفيض CARE

برامج المساعدة الحكومية:
إذا كنت أنت أو أي من أفراد أسرتك تتلقون معونات من أي من البرامج التالية: Medi-Cal أو Medicaid Medi-Cal for Families A & B Women, Infants, & Children (WIC) CalWORKs (TANF) أو Tribal TANF Head Start Income Eligible - Tribal Only Bureau of Indian Affairs General Assistance CalFresh (Food Stamps) National School Lunch Program (NSLP) Low Income Home Energy Assistance Program Supplemental Security Income (SSI)

أو

الحد الأعلى لدخل العائلة*: *(ساري المفعول من 1 حزيران 2014 إلى 31 مايو* ***2015****)* * دخل العائلة الجاري من جميع المصادر قبل الحسم	
عدد أفراد العائلة	الدخل السنوي الإجمالي
2-1	31,460 دولار أمريكي
3	39,580 دولار أمريكي
4	47,700 دولار أمريكي
5	55,820 دولار أمريكي
6	63,940 دولار أمريكي
7	72,060 دولار أمريكي
8	80,180 دولار أمريكي
لكل فرد إضافي في العائلة أضف	8,120 دولار أمريكي+

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 SoCalGas خلال 30 يوما إذا فقدت تأهلك لهذا البرنامج. / قد يُطلب منك إثبات تأهلك 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، والأشرطة والمعاجين الخاصة بمقاومة العوامل الجوية للأبواب والنوافذ، والترميمات المنزلية الصغيرة لمالكي 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.

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

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

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***

Southern California Gas Company
A Sempra Energy utility®

طلب تخفيض 20% خاص ببرنامج CARE

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

Form 6491-E ARA (06/14)
Southern California Gas Company
CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1

اسم المشترك (كما يظهر على الفاتورة):

العنوان (اسم الشارع والمدينة والرمز البريدي):

رقم الحساب

رقم الهاتف ( ) -

البريد الإلكتروني

2

عدد أفراد العائلة البالغين والأطفال الساكنين في المنزل : ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+:

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

○ **نعم** *(إذا أجبت بنعم، ضع علامة أمام البرنامج أو البرامج التي تشارك فيها)* ▼

○ Low Income Home Energy Assistance Program (LIHEAP)
○ Supplemental Security Income (SSI)
○ National School Lunch Program (NSLP)
○ Bureau of Indian Affairs General Assistance
○ Head Start Income Eligible– قبلي فقط

○ Medi-Cal / Medicaid: أقل من 65 سنة
○ Medi-Cal / Medicaid: 65 سنة أو أكثر
○ Medi-Cal for Families A & B
○ Women, Infants, and Children Program (WIC)
CalWORKs (TANF) أو Tribal TANF
○ CalFresh (Food Stamps)

○ **لا**

ما هو دخل العائلة السنوي (قبل الخصومات، بما فيه جميع أفراد العائلة)؟▼

○ 0 – 31,460دولار ○ 31,461– 39,580 دولار ○ 39,581 – 47,700 دولار ○ 47,701 – 55,820 دولار ○ 55,821 – 63,940 دولار

○ إذا زاد عن الدخل عن 63,940 دولار ضع الرقم هنا: , .00 دولار أمريكي في السنة

الرجاء وضع علامة أمام مصدر أو مصادر دخلك:▼

○ نفقة زوجية أو نفقة طفل
○ منح أو منح مدرسية أو منح أخرى تُستعمل لنفقات العيش
○ إيجار أو علاوات
○ نقد أو مصدر دخل آخر

○ المرتبات والأجور و/أو أرباح من عمل حر
○ تعويضات العاطلين عن العمل
○ تسويات قانونية أو تأمين
○ تعويضات عجز (إعاقة) أو تعويضات العاملين

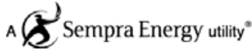
○ Social Security
○ SSP أو SSDI
○ معاش
○ فوائد أو أرباح من: حسابات ادخار أو أسهم أو سندات أو حسابات تقاعد

3

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

التوقيع : X **التاريخ :** / /

Source Code: 9B



Form 6491-E ARM (06/14)

20% CARE ԶԵՂՉԻ ԴԻՄՈՒՄ

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

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

ԻՆՉՊԵՍ ՊԱՅՄԱՆՈՒՆԱԿ ԴԱՌՆԱԼ ԶԵՂՉԻՆ

ՀԱՍԱՐԱԿԱԿԱՆ ՕԳՆՈՒԹՅԱՆ ԾՐԱԳՐԵՐԸ՝

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

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

ԿԱՄ

ԱՌԱՎԵԼԱԳՈՒՅՆ ԸՆՏԱՆԵԿԱՆ ԵԿԱՄՈՒՏ՝
(ուժի մեջ է 2014 թ. հունվարի 6-ից մինչև 2015 թ. մայիսի 31-ը)
*ներկա ընտանեկան եկամուտը բոլոր աղբյուրներից՝ մինչև կրճատումները

Ընտանիքի անդամների թիվը	Ընդհ. տարեկան եկամուտը
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Ընտանիքի յուրաքանչյուր լրացուցիչ անդամ	+$8,120

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 SoCalGas -ին 30 օրվա ընթացքում, եթե այլևս պայմանունակ չեք: / Ձեզանից կարող է խնդրվել ստուգել CARE-ի Ձեր պայմանունակությունը:

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

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, գազօջախ 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:

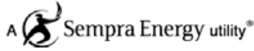
LIHEAP- Low Income Home Energy Assistance Program մատակարարում է հաշիվների վճարման օգնություն, վթարների օգնություն § եղանակի հետ կապված ծառայություններ: Զանգահարեք California Department of Community Services and Development1-866-675-6623 հեռախոսի համարով:

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

ՀԱՃԱԽՈՐԴՆԵՐԻ ՕԺԱՆԴԱԿՈՒԹՅԱՆ ԼՐԱՑՈՒՑԻՉ ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐԻ ՀԱՄԱՐ՝

1-888-427-1345

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



CARE 20% Գնային Զեղչի Դիմում

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

Form 6491-E ARM (06/14)

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

1

Հաճախորդի Անուն՝ (ինչպես Ձեզ ուղարկվող հաշիվներում)

Տան հասցե՝ (փողոց, քաղաք, ԻՆԴԵՔՍ)

Հաշվեհամար՝ ☐☐☐ ☐☐☐ ☐☐☐☐

Հեռախոսահամար՝ (☐☐☐)☐☐☐-☐☐☐☐

էլեկտրոնային հասցե՝

2

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

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

○ <u>ԱՅՈ</u> *(Եթե այո, ապա նշեք որ ծրագ(եր)ին եք մասնակցում* ▼

- ○ Medi-Cal / Medicaid: մինչ§ 65 տարեկան
- ○ Medi-Cal / Medicaid: 65 տարեկան կամ ավել
- ○ Medi-Cal for Families A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ CalWORKs (TANF) ԿԱՄ Tribal TANF
- ○ CalFresh (Սննդի կտրոններ)
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch Program (NSLP)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Tribal Only

○ <u>ՈՉ</u>

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

○ $0-$31,460 ○ $31,461-$39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821- $63,940

○ Եթե $63,940-ից ավել է, ապա գումարը մուտքագրեք այստեղ. $ ☐☐,☐☐☐00 տարեկան

Խնդրվում է նշել Ձեր եկամտի աղբյուրները. ▼

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

3

Համաձայն եք արդյո՞ք հետևյալին: Խնդրում ենք կարդալ և ստորագրել:

Ես հայտնում եմ, որ այս դիմումի մեջ իմ մատակարարած տեղեկությունները ճշմարիտ են և ճշգրիտ: Ես համաձայն եմ մատակարարել CARE պայմանունակության ապացույց, եթե այն խնդրվի: Ես համաձայն եմ տեղեկացնել SoCalGas -ին, եթե այլ§ս որակավորված չլինեմ զեղչը ստանալու: ես հասկանում եմ, որ եթե ես զեղչը ստանամ առանց որակավորված լինելու, ինձանից կարող է պահանջվել վերադարձնել ստացած զեղչը: Ես հասկանում եմ, որ SoCalGas-ն կարող է իմ տեղեկությունները կիսել այլ կենցաղային սպասարկման հիմնարկների կամ գործակալների հետ, որպեսզի ես մասնակցեմ նրանց օգնության ծրագրերին:

Ստորագրություն՝ X **Ամսաթիվ՝** ☐☐ / ☐☐ / ☐☐

Southern California Gas Company

A Sempra Energy utility®

Form 6491-E FAR (06/14)

تقاضانامه تخفیف 20% مراقبت برای

برنامه نرخهای جایگزین شرکت گاز در کالیفرنیا جنوبی ((Southern California Gas Company (SoCalGas®) برای نیرو (CARE) جهت خانوارهای واجد شرایط، 20% تخفیف در قبض ماهیانه گاز. آنهایی که واجد شرایط بوده و درظرف 90 روز ازشروع اشتراک جدید گاز مورد تایید قرار گیرند، همچنین 15 دلار تخفیف درهزینه راه اندازی خدمات دریافت خواهند کرد. تخفیف زمانی تعلق می‌گیرد که تقاضانامه تکمیل و امضاء شده شما توسط شرکتهای SoCalGas تصویب شده باشد.

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

چگونه می‌توانید واجد شرایط تخفیف مراقبت (CARE DISCOUNT) شوید:

برنامه‌های کمک عمومی:

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

(Medicaid), مدیکل (Medi-Cal), خانواده های مدی کل برای خانواده ها الف و ب (Medi-Cal for Families A & B)
یارانه 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 کمک‌های عمومی امور سرخپوستان
(کوپن غذائی) CalFresh
برنامه ملی ناهار رایگان در مدارس (NSLP)
برنامه کمک نیروی مسکن برای افراد کم درآمد (LIHEAP)
یارانه درآمد تأمین اجتماعی (SSI)

یا

حـداکثـر درآمـد خـانـوار*:

(تاریخ اعتبار از 1 ما جون 2014 الی 31 ماه می2015)

* درآمد کنونی خانوار شامل تمام منابع درآمد قبل از کسورات

تعداد افراد در خانوار	کل در آمد سالانه
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
برای هر فرد اضافی	+8,120

شرایط برای شرکت کردن

قبض گاز باید به نام شما و آدرس باید آدرس اصلی شما باشد. / کسی به غیر از همسرتان 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 می‌بایست شرکت SoCalGas را ظرف 30 روز مطلع سازید. / ممکن است از شما خواسته شود تا صلاحیت خود را برای CARE نشان دهید.

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

Energy Savings Assistance Program

برنامه کمک برای صرفه جویی نیرو : بهینه سازی رایگان مسکن برای صرفه جویی نیرو، به شمول عایق‌سازی سقف، روزنه‌گیری درب، درزگیری و تعمیرات جزیی منزل، در اختیار صاحبان منازل یا مستأجرین کم درآمد که واجد شرایط باشند قرار می‌دهد. 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 بیماری‌های خاص فراهم می‌کند. برای اطلاعات بیشتر با شماره 1-800-427-2200 تماس بگیرید.

LIHEAP: برنامه کمک نیروی مسکن برای افراد کم در آمد، 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 می‌کند. با سازمان خدمات اجتماعی و عمران کالیفرنیا (California Dept. of Community Services and Development) به شماره 1-866-675-6623 تماس بگیرید.

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

برای اطلاعات بیشتر در مورد کمک به مشتریان:

1-888-427-1345

اشخاصی که مشکل شنوائی دارند ((Hearing Impaired (TDD/TTY) 1-800-252-0259 (صرفا به زبان های انگلیسی و اسپانیولی در دسترس می‌باشد)

فکس: (213) 244-4665

Southern California Gas Company

A Sempra Energy utility®

تقاضا نامه تخفیف نرخ مراقبت CARE 20%

لطفا با جوهر تیره رنگ وحروف درشت و خوانا بنویسید تا رسیدگی مناسب تضمین گردد

روش صحیح برای پر کردن دایره ها: ●

Form 6491-E FAR (06/14)

Southern California Gas Company
CARE PROGRAM, ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249

1

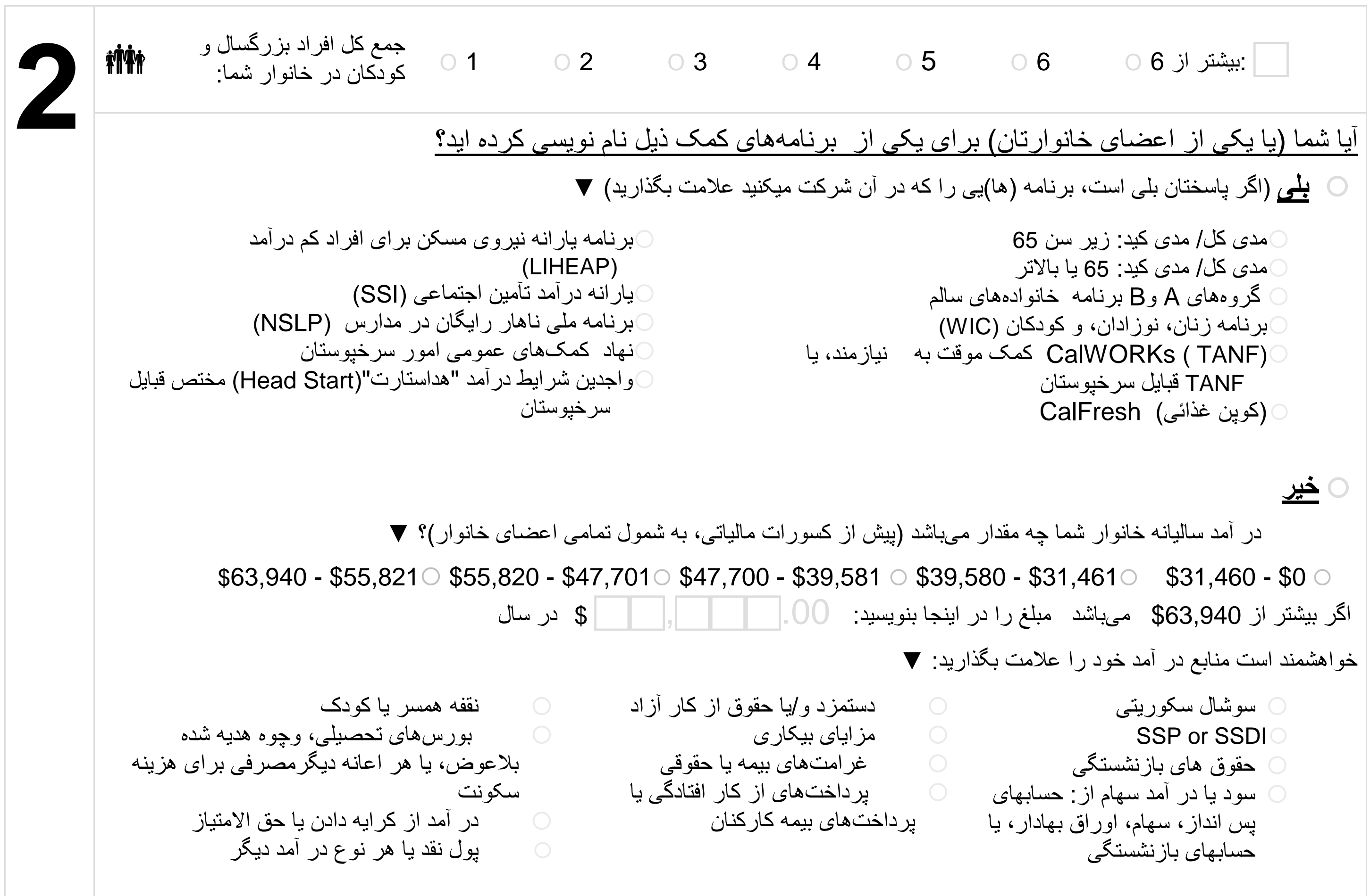
نام و نام خانوادگی مشتری (به صورتی که روی قبض شما درج شده است):

نشانی منزل (خیابان، شهر، کد پستی):

شماره حساب: ☐☐☐ ☐☐☐ ☐☐☐☐

شماره تلفن: (☐☐☐)☐☐☐-☐☐☐☐

نشانی پست الکترونیک یا ایمیل:



2

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

آیا شما (یا یکی از اعضای خانوارتان) برای یکی از برنامه‌های کمک ذیل نام نویسی کرده اید؟

○ **بلی** (اگر پاسختان بلی است، برنامه (ها)یی را که در آن شرکت میکنید علامت بگذارید) ▼

○ مدی کل/ مدی کید: زیر سن 65
○ مدی کل/ مدی کید: 65 یا بالاتر
○ گروه‌های A وB برنامه خانواده‌های سالم
○ برنامه زنان، نوزادان، و کودکان (WIC)
○ CalWORKs (TANF) کمک موقت به نیازمند، یا TANF قبایل سرخپوستان
○ CalFresh (کوپن غذائی)
○ برنامه یارانه نیروی مسکن برای افراد کم درآمد (LIHEAP)
○ یارانه درآمد تأمین اجتماعی (SSI)
○ برنامه ملی ناهار رایگان در مدارس (NSLP)
○ نهاد کمک‌های عمومی امور سرخپوستان
○ واجدین شرایط درآمد "هداستارت"(Head Start) مختص قبایل سرخپوستان

○ **خیر**

در آمد سالیانه خانوار شما چه مقدار می‌باشد (پیش از کسورات مالیاتی، به شمول تمامی اعضای خانوار)؟ ▼

○ $31,460 - $0 ○ $39,580 - $31,461 ○ $47,700 - $39,581 ○ $55,820 - $47,701 ○ $63,940 - $55,821

اگر بیشتر از $63,940 می‌باشد مبلغ را در اینجا بنویسید: .00 ☐☐☐,☐☐ $ در سال

خواهشمند است منابع در آمد خود را علامت بگذارید: ▼

○ سوشال سکوریتی
○ SSP or SSDI
○ حقوق های بازنشستگی
○ سود یا در آمد سهام از: حسابهای پس انداز، سهام، اوراق بهادار، یا حسابهای بازنشستگی
○ دستمزد و/یا حقوق از کار آزاد
○ مزایای بیکاری
○ غرامت‌های بیمه یا حقوقی
○ پرداخت‌های از کار افتادگی یا پرداخت‌های بیمه کارکنان
○ نفقه همسر یا کودک
○ بورس‌های تحصیلی، وجوه هدیه شده بلاعوض، یا هر اعانه دیگرمصرفی برای هزینه سکونت
○ در آمد از کرایه دادن یا حق الامتیاز
○ پول نقد یا هر نوع در آمد دیگر

3

آیا با محتوی متن ذیل موافق هستید؟ خواهشمند است متن را خوانده، در ذیل امضاء کنید:
اظهار می‌کنم اطلاعاتی را که در این تقاضا نامه ارائه داده ام صحیح و درست هستند. موافقت می‌کنم اگر از من خواسته شود، مدارک اثبات واجد شرایط بودن CARE را ارائه کنم. موافقت می‌کنم اگر دیگر واجد شرایط دریافت تخفیف نباشم، به شرکت SoCalGas اطلاع دهم. آگاه هستم اگر بدون داشتن شرایط لازمه تخفیف دریافت کنم، ممکن است وادار به پس دادن تخفیف دریافتی بشوم. آگاهم که شرکت SoCalGas می‌تواند اطلاعات مربوطه مرا با سایر شرکت‌های آب یا برق یا گاز یا عاملین جهت نام نویسی اینجانب در برنامه‌های یارانه آنها در میان بگذارد.

امضاء: X **تاریخ:** ☐☐ / ☐☐ / ☐☐

Form 6491-E HMO (06/14)

CARE DAIM NTAWV THOV KEV PAB LUV NQI 20%

Lub Lag Luam Tso Roj Zeb Ntsuam (Southern California Gas Company(SoCalGas®)) 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 ntxiv 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 (SoCalGas) 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
Medi-Cal rau cov tsev neeg A&B
Nyiaj Pab Poj Niam thiab Menyuam 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 (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 TSIS PUB TSEV NEEG TAU DHAU*:
(Zoo los ntawm Lub rau hli ntuj 1, 2014 mus rau Tej zaum 31, 2015)
*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 Xyoos
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Ib Tug Neeg Twg Ntxiv	+$8,120

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 (SoCalGas) 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 THIAB 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 pheej 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 Tswj 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 pheej 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 NTAWV 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.

Txoj Kev Kos Lub Voj Kom Yog●

Form 6491-E HMO (06/14)

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

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 Nyoog Qis Dua 65
- ○ Medi-Cal / Medicaid: 65 xyoos los Laus Dua
- ○ Medi-Cal rau Tsev Neeg A & B
- ○ Nyiaj Pab Poj Niam thiab Me Nyuam Kev Noj Kev Haus (WIC)
- ○ CalWORKs (TANF) los sis Pab Pawg Neeg TANF
- ○ CalFresh (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)
- ○ 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 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Yog tias tau ntau tshaj $63,940, 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

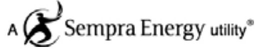
3

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 ntaub 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 (SoCalGas) 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 (SoCalGas) muaj cai muab kuv cov ntaub 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: ☐☐ / ☐☐ / ☐☐



Form 6491-E KH (06/14)

ពាក្យសុំចុះតម្លៃ 20 ភាគរយ ពីកម្មវិធីឃែរ (CARE)

កម្មវិធីនៃតម្លៃថាមពលនានារដ្ឋកាលីហ្វ័រញ៉ា (California Alternate Rates for Energy - CARE) របស់ក្រុមហ៊ុនហ្គាស (Southern California Gas Company (SoCalGas ®)) ផ្តលការចុះតម្លៃ 20 ភាគរយនៃការចុះតម្លៃចំពោះសំបុត្រ ទារលុយសំរាប់ផ្ទះសំបែងណាដែលមានលក្ខណ:គ្រប់គ្រាន់ទទួលកម្មវិធីនោះ ។ លោកអ្នកដែលមានលក្ខណៈគ្រប់គ្រាន់ទទួល ហើយ ត្រូវបានអនុញ្ញាតក្នុងកំឡុង 90 ថ្ងៃនៃការចាប់ផ្តើមសេវាកម្មហ្គាសថ្មី ក៏នឹងទទួលការចុះតម្លៃ $15 នៃតម្លៃតម្លើងស្ថាបនាសេវាកម្ម (Service Establishment Charge) ។ ការចុះតម្លៃ នឹងអនុវត្តពេលលោកអ្នកបំពេញ និងចុះហត្ថលេខាពាក្យសុំនេះ ត្រូវបានសំរេចដោយក្រុមហ៊ុនហ្គាស (SoCalGas)។

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

មធ្យោបាយដើម្បីនឹងមានលក្ខណ:គ្រប់គ្រាន់ទទួលសំរាប់ការចុះតម្លៃ :

កម្មវិធីជំនួយសាធារណ:
បើលោកអ្នក ឬនរណាម្នាក់ទៀតនៅក្នុងផ្ទះរបស់លោកអ្នក ចូលរួមកម្មវិធីណាមួយដូចតទៅ :
មេឌីខេត មេឌីខាល
សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
ស្ត្រី ទារក ហើយនិង កុមារ (WIC)
ខលវើក (CalWORKs [TANF]) ទ្រីបលតែនហ្វ (Tribal TANF)
ឬ សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច
ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance)
ខលហ្រេស CalFresh (Food Stamps)
កម្មវិធីអាហារថ្ងៃត្រង់តតតិតថ្លៃរបស់កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch Program - NSLP)
កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
ចំណូលសេត្ស៊ូរិទីបន្ថែម (Supplemental Security Income - SSI)

ចំណូលគ្រួសារអតិបរមា *:
(មានប្រសិទ្ធិភាពពីថ្ងៃទី 1 ខែមិថុនាឆ្នាំ 2014 ដល់ខែឧសភា 31, ឆ្នាំ 2015)

*ចំណូលគ្រួសារបច្ចុប្បន្នមកពីប្រភពទាំងអស់មុនពេលកាត់ទុក

ចំនួននៃមនុស្សរស់នៅក្នុងផ្ទះ	ចំនួនថវិកាស្រុបរាល់ឆ្នាំ
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
មនុស្សម្នាក់ៗបន្ថែម	+$8,120

លក្ខខណ្ឌចំពោះការចូលរួម

សំបុត្រទារលុយហ្គាសត្រូវតែមានឈ្មោះ និងអាសយដ្ឋានរបស់លោកអ្នក ហើយត្រូវតែមានអាសយដ្ឋានចំបងរបស់លោកអ្នក ។ / លោកអ្នកមិនត្រូវធ្វើដាក់ឈ្មោះកូនជាកូនបិតនៅក្នុងបន្ទុកសំអាងទៅលើថវិកានៃនរណាម្នាក់ទៀត ជាជាងប្រពន្ធឬប្តីរបស់លោកអ្នកឡើយ ។ / លោកអ្នកត្រូវតែដាក់ស្នើសុំការបញ្ជាក់ម្តងទៀតចំពោះពាក្យសុំរបស់លោកអ្នក នៅពេលស្នើសុំ ។ / លោកអ្នកត្រូវតែប្រាប់ក្រុមហ៊ុនហ្គាស (SoCalGas) អោយដឹងយ៉ាងហោចណាស់ 30 ថ្ងៃ បើលោកអ្នកពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលទៀត ។ / លោកអ្នកប្រហែលជាត្រូវបានស្នើសុំអោយបញ្ជាក់នូវលក្ខណៈគ្រប់គ្រាន់ទទួលកម្មវិធីឃែរ (CARE) របស់លោកអ្នក។

កម្មវិធី និងសេវាកម្មឯទៀត ដែលលោកអ្នកមានលក្ខណ:គ្រប់គ្រាន់ទទួលនឹងទទួល :

កម្មវិធីផ្តល់ជំនួយសន្សំសំចៃថាមពល (Energy Savings Assistance Program) : ផ្តល់ការកែលំអផ្ទះសំបែងសន្សំសំចៃថាមពលដោយមិនអស់លុយដូចជា ការដាក់ទ្រនាប់នៅលើពិតាន បន្ទះបិទបង្អាំងធាតុអាកាសតាមចន្លោះទ្វារ ការបិទថ្នាំការបិទ និងការជួសជុល តិចតួចនៃផ្ទះសំបែងដល់ទាំងម្ចាស់ និងអ្នកជួលដែលមានប្រាក់ចំណូលទាប។ សំរាប់ព័ត៌មានបន្ថែម សូមទូរស័ព្ទលេខ 1-800-331-7593 ។

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

លីហេប (LIHEAP) : កម្មវិធីជំនួយខាងថាមពលនៃផ្ទះសំបែងដែល មានថវិកាតិច ផ្តល់ជាជំនួយខាងសំបុត្រទារលុយ ជំនួយខាងសំបុត្រទារលុយបន្ទាន់ ហើយនិងសេវាកម្ម ខាងរំដោះធាតុអាកាស ។ ទូរស័ព្ទ ក្រសួងសេវាកម្មសហគមន៍រដ្ឋកាលីហ្វរញ៉ា (California Dept. of Community Services) លេខ 1-866-675-6623 ។

ខ្សែនៃជីវិតរដ្ឋកាលីហ្វរញ៉ា (California Lifeline): លទ្ធភាពចំពោះទូរស័ព្ទដោយមានតម្លៃថោក សំរាប់អ្នកទិញដែលមានលក្ខណ: គ្រប់គ្រាន់ទទួលបំពេញតាមការណែនាំពីចំណូលរបស់កម្មវិធីឃែរ (CARE)។ សំរាប់ព័ត៌មានបន្ថែម សូមទាក់ទងអ្នកផ្តល់សេវាកម្មខាង ទូរស័ព្ទប្រចាំស្រុករបស់លោកអ្នក ។

សំរាប់ព័ត៌មានអំពីជំនួយអតិថិជន:

1-888-427-1345

ខូចត្រចៀក **(TDD/TTY): 1-800-252-0259** (ជាភាសាអង់គ្លេស និង អេស្ប៉ាញប៉ុណ្ណោះ)

ទូរសារ **(213)244-4665**

ពាក្យសុំចុះតម្លៃ 20% នៃកម្មវិធីឃែរ (CARE)

សូមប្រើទឹកប៊ិចខ្មៅ ហើយសរសេរដោយផ្ចិតផ្ចង់ដើម្បីបញ្ចៀសការយឺតយ៉ាវ ហើយមានភាពត្រឹមត្រូវ

វិធីត្រឹមត្រូវគូសរង្វង់មូល: ●

Form 6491-E KH (06/14)

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

1

ឈ្មោះរបស់អ្នកទិញ (ដូចមានលើសំបុត្រទារលុយ):

អាសយដ្ឋាន (រដ្ឋ ក្រុង កូដតំបន់):

លេខកុង: ☐☐☐ ☐☐☐ ☐☐☐☐

លេខទូរស័ព្ទ: (☐☐☐)☐☐☐-☐☐☐☐

អាសយដ្ឋានអ៊ីមែល:

2

ចំនួនមនុស្សពេញវ័យ និងក្មេងក្នុងគ្រួសាររបស់លោកអ្នកសរុប: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 6+: ☐

តើលោកអ្នក (រឺនរណាម្នាក់ក្នុងគ្រួសាររបស់លោកអ្នក) ចូលរួមក្នុងកម្មវិធីជំនួយណាមួយខាងក្រោមរឺទេ?

○ **មាន** *បើមាន សូមគូសកម្មវិធីចូលរួម)*▼

- ○ មេឌីខែត/មេឌីខាល: ក្រោម 65 ឆ្នាំ
- ○ មេឌីខែត/មេឌីខាល: លើ 65 ឆ្នាំ រឺលើសនេះ
- ○ សុខភាពក្រុមគ្រួសារតាមប្រភេទ A&B
- ○ កម្មវិធីស្ត្រី ទារក ហើយនិង កុមារ (WIC)
- ○ ខលវើក (CalWORKs [TANF]) ទ្រីបលថែនហ្វ (Tribal TANF)
- ○ ខលហ្វ្រេស CalFresh (Food Stamps)
- ○ កម្មវិធីជំនួយថាមពលនៅផ្ទះដែលមានចំណូលទាប (Low Income Home Energy Assistance Program - LIHEAP)
- ○ ចំណូលសេគ្គូរីទីបន្ថែម (Supplemental Security Income - SSI)
- ○ កម្មវិធីអាហារថ្ងៃត្រង់ឥតគិតថ្លៃរបស់កម្មវិធីអាហារថ្ងៃត្រង់នៅសាលាជាតិ (National School Lunch Program - NSLP)
- ○ ជំនួយទូទៅរបស់ការិយាល័យកិច្ចការឥណ្ឌា (Bureau of Indian Affairs General Assistance)
- ○ សិទ្ធិបានចំណូលដំបូង (Head Start Income Eligible) - សម្រាប់តែជនជាតិភាគតិច

○ **មិនមាន**

តើចំណូលគ្រួសារប្រចាំឆ្នាំរបស់លោកអ្នក (មុនពេលកាត់ រួមសមាជិកគ្រួសារទាំងអស់) មានប៉ុន្មាន? ▼

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ បើច្រើនជាង $63,940 សូមបញ្ចូលចំនួននៅទីនេះ : $ ☐☐,☐☐☐.00

ក្នុងមួយឆ្នាំ **គូសយកប្រភពចំណូលរបស់លោកអ្នក:** ▼

- ○ សូស្យាល់សេគ្គូរីទី
- ○ SSP រឺ SSDI
- ○ លុយរឺត្រែត
- ○ ការប្រាក់ ឬកំរៃក្រុមហ៊ុនពី: កុងសន្សំប្រាក់ Stocks, Bonds រឺលុយរឺត្រែត
- ○ ប្រាក់ខែ និង/ឬប្រាក់ចំណេញពីពាណិជ្ជកម្មផ្ទាល់ខ្លួន
- ○ ប្រាក់អត្ថប្រយោជន៍ពីការឥតការធ្វើ
- ○ ប្រាក់មកពីអិនស្សូរិន រឺប្រាក់មកពីការកាត់សេចក្តី
- ○ ប្រាក់ពិការ រឺសំណងកម្មករ
- ○ ប្រាក់ជំនួយពីប្តីឬប្រពន្ធ រឺជំនួយកូន
- ○ ប្រាក់ជំនួយអាហារូបករណ៍ ជំនួយ រឺជំនួយឯទៀតប្រើសំរាប់ការចាយវាយនៃជីវភាព
- ○ ប្រាក់មកពីការជួល រឺសួយសារ
- ○ ប្រាក់សុទ្ធ /ឬថវិកាឯទៀត

3

តើលោកអ្នកព្រមចំពោះការរៀបរាប់ខាងក្រោមទេ? សូមអាន ហើយចុះហត្ថលេខាខាងក្រោម ។

ខ្ញុំសូមថ្លែងថាព័ត៌មានដែលខ្ញុំបានផ្តល់នៅក្នុងពាក្យសុំនេះ គឺពិតហើយត្រូវ ។ ខ្ញុំយល់ព្រមនឹងផ្តល់នូវភស្តុតាងសំរាប់លក្ខណៈគ្រប់គ្រាន់ទទួលកម្មវិធីឃែរ (CARE) ប្រសិនជាត្រូវបានស្នើសុំ ។ ខ្ញុំយល់ព្រមនឹងប្រាប់ក្រុមហ៊ុនហ្គាស (SoCalGas) ប្រសិនបើខ្ញុំពុំមានលក្ខណៈគ្រប់គ្រាន់ទទួលដើម្បីនឹងទទួលការចុះថោកទេ ។ ខ្ញុំយល់ថា បើខ្ញុំទទួលការចុះថោកដោយមិនមានលក្ខណៈគ្រប់គ្រាន់ទទួល ខ្ញុំអាចត្រូវបានតំរូវអោយបង់សងការចុះថោកដែលខ្ញុំបានទទួល ។ ខ្ញុំយល់ថា ក្រុមហ៊ុនហ្គាស (SoCalGas) អាចចែកចាយព័ត៌មានរបស់ខ្ញុំជាមួយនឹងក្រុមហ៊ុន និងភ្នាក់ងារឯទៀតដើម្បីចុះឈ្មោះខ្ញុំនៅក្នុងកម្មវិធីជំនួយរបស់គេ ។

ហត្ថលេខា: **X** ____________________ ថ្ងៃខែ: ☐☐ / ☐☐ / ☐☐

Form 6491-E RU (06/14)

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 Southern California Gas Company (SoCalGas®) 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 получат 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 SoCalGas.

Пожалуйста, заполните и верните заявление по почте либо заполните его онлайн на вебсайте socalgas.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
Medi-Cal для семей категорий A и 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 (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 июня 2014 года по 31 мая 2015)
*семейный доход в настоящий момент из всех источников без учета отчислений

Кол-во членов семьи	Общий годовой доход
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
На каждого дополнительного члена семьи добавьте	+$8,120

УСЛОВИЯ ДЛЯ УЧАСТИЯ В ПРОГРАММЕ

Счет за газ должен быть оформлен на ваше имя и приходить 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 SoCalGas в течение 30 дней, если вы 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.

LIHEAP: 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 похожим на условия 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)

Southern California Gas Company

A Sempra Energy utility®

Заявление на получение льгот в размере 20% по программе CARE

Form 6491-E RU (06/14)

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))* ▼

- ○ Medi-Cal / Medicaid: младше 65 лет
- ○ Medi-Cal / Medicaid: 65 лет и старше
- ○ Medi-Cal для семей категорий A и B
- ○ Women, Infants, and Children Program (WIC)
- ○ CalWORKs (TANF) или Tribal TANF
- ○ CalFresh (Food Stamps) (Продовольственные талоны)
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch Program (NSLP)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Только для коренного населения США

○ **НЕТ**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Если больше $63,940, то укажите сумму здесь: $ . .00 в год

Пожалуйста, укажите источники вашего дохода: ▼

- ○ Social Security (Социальное пособие)
- ○ SSP или SSDI
- ○ Пенсии
- ○ Процентный доход или дивиденды: сберегательные счета, акции, облигации или пенсионные счета
- ○ Зарплата и/или доход от инд. предпр. деятельности
- ○ Пособие по безработице
- ○ Страховые выплаты или выплаты по искам
- ○ Пособие по инвалидности или компенсации за травмы на работе
- ○ Пособие на супруга (супругу) или алименты на ребенка
- ○ Стипендии, гранты или иные компенсации на проживание
- ○ Доходы от аренды или гонорары
- ○ 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 участи в программе CARE. Я обязуюсь уведомить компанию SoCalGas, если я не стану соответствовать требованиям, необходимым для получения льгот. В том случае, если я продолжу получать скидку, не соответствуя необходимым на то требования, от меня могут потребовать вернуть полученную скидку. Я отдаю себе отчет в том,что компании SoCalGas может передавать мою личную информацию другим поставщикам бытовых услуг или их представителям с целью моей последующей регистрации в их программах социальной помощи.

Подпись: X **Дата:** / /

Southern
California
Gas Company

Form 6491-E TAG (06/14)

APPLICATION PARA SA 20% NA DISKUWENTO SA CARE

Ang California Alternate Rates for Energy (CARE) program ng Southern California Gas Company (SoCalGas®) 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 SoCalGas ang inyong kumpleto at nilagdaang application form.

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

PAANO MAGING KWALIPIKADO PARA SA DISKUWENTONG CARE:

MGA PROGRAMANG NAGBIBIGAY NG TULONG SA MADLA:

Kung kayo o isa sa inyong mga kasambahay ay nakikilahok sa alinman sa mga sumusunod na programa:

Medicaid o Medi-Cal
Medi-Cal para sa mga pamilya A & B
Women, Infants & Children (WIC)
CalWORKs (TANF) o Tribal TANF
Head Start Income Eligible – Tribal Lamang
Bureau of Indian Affairs General Assistance
CalFresh (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

O

MGA HANGGANAN NG KITA NG SAMBAHAYAN*:
(may-bisa Hunyo 1, 2014 hanggang Mayo 31, 2015)
*kasalukuyang kita ng sambahayan mula sa lahat ng pinagkukunan bago mga kabawasan

Bilang ng Tao sa Sambahayan	Kabuuang Kita para sa Taon
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Bawat Dagdag na Tao	+$8,120

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 SoCalGas 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™

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.

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-E TAG (06/14)

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)*▼

- ○ Medi-Cal / Medicaid: Mas mababa kaysa Edad 65
- ○ Medi-Cal / Medicaid: 65 o higit
- ○ Medi-Cal para sa mga pamilya A & B
- ○ Women, Infants, and Children Program (WIC)
- ○ CalWORKS (TANF) o Tribal TANF
- ○ CalFresh (Food Stamps)
- ○ Low Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch Program (NSLP)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Tribal Lamang

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Kapag higit sa $63,940, ilagay halaga dito: $ ☐☐,☐☐☐.00 bawat taon

Pakisuyong markahan ang mga pinagkukunan ninyo ng kita: ▼

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

3

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

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

Lagda: X **Petsa:** ☐☐/☐☐/☐☐

Southern California Gas Company
A Sempra Energy utility®

20% CARE DISCOUNT

ใบสมัครเข้าร่วมโครงการ

โครงการ California Alternate Rates for Energy (CARE) โดย Southern California Gas Company (SoCalGas®) มอบส่วนลด 20% ของค่าบริการการใช้ก๊าซรายเดือนให้กับครัวเรือนที่มีสิทธิ์เข้าร่วมโครงการ
ผู้ที่ผ่านข้อกำหนดและได้รับการตอบรับเข้าร่วมโครงการภายใน 90 วันหลังจากการเริ่มต้นรับบริการใช้ก๊าซธรรมชาติจะได้รับส่วนลดอีก $15 สำหรับค่าธรรมเนียมเริ่มต้นบริการ (Service Establishment Charge)
ทั้งนี้ท่านจะได้รับส่วนลดต่อเมื่อท่านกรอกข้อมูลและลงนามในใบสมัครอย่างครบถ้วน
และหลังจากใบสมัครของท่านได้รับการอนุมัติจาก SoCalGas

กรุณากรอกใบสมัครให้ครบถ้วนและส่งกลับ หรือสมัครผ่านระบบออนไลน์ที่ socalgas.com (ค้นหาโดยใช้คำว่า “CARE”)

วิธีในการผ่านเกณฑ์สำหรับการรับส่วนลด THE CARE DISCOUNT:

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

หรือ

รายได้รวมสูงสุดของครัวเรือน*: *(มีผลตั้งแต่ 1 มิถุนายน 2014 ถึง 31 พฤษภาคม 2015)* *รายได้รวมปัจจุบันของครัวเรือนจากทุกแหล่งรายได้ก่อนหักลดหย่อนภาษี	
จำนวนสมาชิกในครัวเรือน	รายได้รวมต่อปี
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
สมาชิกในครัวเรือนที่เพิ่มเติมให้เพิ่มอีกคนละ	+$8,120

ข้อกำหนดสำหรับผู้เข้าร่วมโครงการ

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

โครงการและบริการอื่นๆ ที่ท่านอาจผ่านเกณฑ์ในการเข้าร่วม:

Energy Savings Assistance Program™

Energy Savings Assistance Program: (โครงการช่วยเหลือด้านการประหยัดพลังงาน)
เป็นโครงการที่มอบความช่วยเหลือในการปรับปรุงบ้านเพื่อการประหยัดพลังงานโดยไม่เสียค่าใช้จ่าย เช่น การติดตั้งฉนวนใต้ฝ้าเพดาน การปิดช่องประตู การอุดรอยแตกร้าว 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 ท่านสามารถติดต่อสอบถามข้อมูลได้ที่สำนักงานบริการและการพัฒนาชุมชนแห่งรัฐแคลิฟอร์เนีย (California Department of Community Services and Development) ที่หมายเลขโทรศัพท์ 1-866-675-6623

California Lifeline: (โครงการส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้น้อยของรัฐแคลิฟอร์เนีย)
โครงการนี้จะมอบส่วนลดค่าบริการโทรศัพท์สำหรับผู้ใช้บริการที่มีรายได้อยู่ในเกณฑ์เดียวกับผู้มีสิทธิเข้าร่วมโครงการ CARE ท่านสามารถโทรสอบถามข้อมูลเพิ่มเติมได้จากผู้ให้บริการโทรศัพท์ในท้องที่ของท่าน

สอบถามข้อมูลเพิ่มเติมได้ที่แผนกลูกค้าสัมพันธ์:

1-888-427-1345

แฟกซ์ **(213)244-4665**

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

Southern California Gas Company

A Sempra Energy utility®

ใบสมัคร CARE 20% Rate Discount

กรุณากรอกข้อมูลให้ครบถ้วนด้วยตัวบรรจงโดยใช้หมึกสีเข้ม

ฝนทำเครื่องหมายวงกลม: ●

Form 6491-E TH (06/14)

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

1

ชื่อลูกค้า (ตามใบแจ้งหนี้):

ที่อยู่ (ถนน, เมือง, รหัสไปรษณีย์):

หมายเลขบัญชี:

หมายเลขโทรศัพท์: ( ) -

อีเมล์:

2

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

ท่าน (หรือสมาชิกในครัวเรือนของท่าน) ได้รับสิทธิประโยชน์จากโครงการดังต่อไปนี้หรือไม่?

○ **YES** *(ถ้าใช่ ทำเครื่องหมายทุกโครงการที่เข้าร่วม)*▼

- ○ Medi-Cal / Medicaid: อายุน้อยกว่า 65 ปี
- ○ Medi-Cal / Medicaid: อายุ 65 ปีขึ้นไป
- ○ Medi-Cal สำหรับครอบครัว A & B
- ○ โครงการสงเคราะห์สตรี, ทารกแรกเกิด, และเด็ก (WIC)
- ○ CalWORKs (TANF) หรือ Tribal TANF
- ○ CalFresh (แสตมป์อาหาร)
- ○ โครงการให้ความช่วยเหลือด้านพลังงานในบ้านแก่ผู้มีรายได้น้อย (LIHEAP)
- ○ โครงการเสริมรายได้เพิ่มเติมจากเงินประกันสังคม (SSI)
- ○ โปรแกรมอาหารกลางวันฟรีแห่งชาติ (NSLP)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible เฉพาะชนเผ่า

○ **NO**

รายได้ต่อปีของครัวเรือนของท่านคือเท่าไหร่ (รวมสมาชิกในครัวเรือนทุกคนก่อนหักลดหย่อนภาษี)▼

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ หากรายได้ของท่านมากกว่า $63,940 โปรดระบุจำนวนรายได้ที่นี่: $, .00 ต่อปี

กรุณาระบุแหล่งรายได้: ▼

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

3

ท่านเห็นด้วยกับข้อความต่อไปนี้หรือไม่? กรุณาอ่านและลงนามด้านล่าง

ข้าพเจ้ารับรองว่าข้อมูลที่ข้าพเจ้าระบุในเอกสารใบสมัครฉบับนี้ถูกต้องและเป็นความจริง หากมีการร้องขอ ข้าพเจ้ายินยอมที่จะแสดงหลักฐานที่แสดงว่าข้าพเจ้ามีสิทธิ์เข้าร่วมโครงการ CARE ข้าพเจ้าตกลงจะแจ้ง SoCalGas ทันทีที่ข้าพเจ้าขาดสถานภาพในการได้รับส่วนลดจากโครงการ ข้าพเจ้าตกลงว่า หากข้าพเจ้SoCalGasข้าพเจ้าไม่ผ่านเกณฑ์ในการเข้าร่วมโครงการ ข้าพเจ้าอาจต้องจ่ายคืนส่วนลดที่ข้าพเจ้าได้รับ ข้าพเจ้าตกลงว่า SoCalGas สามารถเปิดเผยข้อมูลของข้าพเจ้ากับเจ้าหน้าที่หรือบริษัทสาธารณูปโภคอื่นๆ เพื่อลงทะเบียนข้าพเจ้าในโครงการช่วยเหลืออื่นๆ ได้

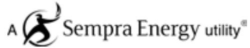
ลายเซ็น: X **วันที่:** / /

SAMPLE FORMS: APPLICATIONS
Self-Recertification CARE Application
Individually Metered Residential (Form 6674-E, 06/14) T

(See Attached Form)

Form 6674-E EN (06/14)

YOUR RATE DISCOUNT IS EXPIRING



Dear Customer: Date:

You are currently receiving a 20% rate discount on your monthly gas bill through Southern California Gas Company (SoCalGas®)'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. 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

2. Visit our Website http://www.socalgas.com/care/recert/ and have your account number ready,

OR

3. Return the completed and signed form by mail or fax.

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
Medi-Cal for 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 (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program (LIHEAP)
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2014 to May 31, 2015)
*current household income from all sources before deductions

Number of Persons in Household	Total Annual Income
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each Additional Person	+$8,120

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.

FOR 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

Account Number:

A Sempra Energy utility®

CARE 20% Rate Discount Recertification Form

Please use BLACK ink and print clearly to ensure proper processing

Correct way to mark circles: ●

Form 6674-E EN (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

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

○ **NO**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, 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 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:** / /

A Sempra Energy utility®

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 Southern California Gas Company (SoCalGas®). 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. Llame al **1-866-716-3452** en cualquier momento las 24 horas al día, 7 días a la semana, y siga las instrucciones para recertificar por teléfono. Por favor tenga listo su número de cuenta. Puede localizar su número de cuenta en la parte inferior de esta página,

O

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

O

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

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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
Medi-Cal Para Familias A & B
Programa para Mujeres, Bebés y Niños (WIC)
CalWORKs (TANF) o TANF Tribal
CalFresh (Estampillas para Comida)
Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa Nacional de Almuerzos Escolares (NSLP)
Buró de Asistencia General para Asuntos de Nativos Americanos
Ingreso elegible para Head Start (tribal únicamente)

O

INGRESO MÁXIMO EN EL HOGAR:
(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

Número de personas en el hogar	Ingreso total anual
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Cada persona adicional	+$8,120

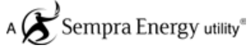
CONDICIONES PARA PARTICIPAR

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 SoCalGas en un término de 30 días si deja de calificar.
Tal vez se le pida comprobar que reúne los requisitos para CARE.

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

Número de cuenta:



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

Form 6674-E SP (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

Por favor use tinta NEGRA 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)* ▼

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Medi-Cal para familias A & B
- ○ Programa para Mujeres, Bebés, y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para Comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa Nacional de Almuerzos Escolares (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **No**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, 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** : __ / __ / __

A Sempra Energy utility®

Form 6674-E CH (06/14)

您的費率折扣即將過期

親愛的客戶：　　　　日期：

您現在正通過 Southern California Gas Company(SoCalGas®)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你的資格：

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

或者

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。

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)、Medi-Cal for 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 (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, 社會安全輔助金)

或者

家庭收入最高限額*:
（有效期2014 年6 月1 日至2015 年5 月31 日）
*包括所有來源的家庭現有稅前收入

家庭成員人數	年收入總額
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
每多一位家庭成員	+$8,120

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 SoCalGas。/ 您有可能被要求提供符合 CARE 資格的證明文件。

若需更多關于 CARE 計劃的資訊，請致電 SOCALGAS：

英語：1-800-427-2200　國語：1-800-427-1429　西班牙語：1-800-342-4545
韓語：1-800-427-0471　粵語：1-800-427-1420　越南語： 1-800-427-0478
聽覺障礙專綫 (TDD/TTY)：1-800-252-0259（僅提供英語和西班牙語服務）
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-E CH (06/14)

請用深色筆以正楷填寫清晰以確保適當受理
正確涂圈方法：●

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
傳真(FAX): (213) 244-4665

1

客戶姓名：

地址：

帳戶號碼：

聯絡電話：( )-

電郵地址：

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

2

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

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*）▼

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

○ 否

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ 如果多于 $63,940，請在此處填寫金額：$, .00 每年

請把您家庭收入所有來源前面的圓圈塗黑：▼

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

3

您同意以下聲明嗎？請您閱讀並簽字。
我願意證明上述申請資料正確屬實。若需要我也同意提供文件證明符合 CARE 的資格。我同意若我不再符合條件時，即通知 SoCalGas。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 SoCalGas 可將有關我的資料提供給其它的公用事業公司和組織團體以協助我加入他們的協助計劃。

簽名：**X** **日期：** / /

A Sempra Energy utility

Form 6674-E KO (06/14)

귀하의 요금 할인이 종료됩니다

친애하는 고객님: 날짜:

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

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

또는

제공된 봉투를 사용하여 작성하고 서명한 증명 양식을 택배나 팩스로 제출합니다.

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 (Medi-Cal for 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 (푸드 스탬프), 학교 점심 프로그램 (National School Lunch Program), 저소득 주택 에너지 지원 프로그램 (LIHEAP), 추가 사회보장 수입 (SSI)

또는

최대 가구 소득*: *(2014. 6. 1 부터 2015. 5. 31 까지 유효)* *세액 공제전 가구의 현재 총소득	
가구의 식구 수	총 연간 소득
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
각 추가 사용자	+$8,120

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 SoCalGas 에 통보해야 합니다.
CARE 에 대한 수혜자격을 입증하도록 요청 받을 수 있습니다.

CARE 에 대한 사항은 아래의 SOCALGAS 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-E KO (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

1

고객 이름:

주소:

구좌 번호:

주택 전화번호: ( ) -

이메일 주소:

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

2

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

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

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

- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 미만
- ○ Medi-Cal / 메디케이드(Medicaid): 65 세 이상
- ○ 가정 건강 유형 (Medi-Cal for Families) A & B
- ○ 여성, 유아 및 어린이 프로그램(WIC)
- ○ CalWORKs (TANF) 또는 인디언 부족 TANF
- ○ CalFresh (푸드 스탬)
- ○ 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 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ $63,940 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간$, .00

귀하의 소득원에 표시하십시오: ▼

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

3

다음 사항에 동의하십니까? 아래 사항을 읽고 서명하십시오.

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

서명: X **날짜:** / /

A Sempra Energy utility®

Form 6674-E VI (06/14)

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 Southern California Gas Company (SoCalGas®). 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:

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

HOẶC

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.

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 (_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 Sáu, 2014 đến 31 tháng Năm, 2015)
*tất cả các nguồn lợi tức hiện tại trước khi khấu trừ của gia đình

Số Người trong Gia Đình	Tổng Lợi Tức Hàng Năm
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Mỗi người bổ sung	+$8,120

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 SoCalGas 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 SOCALGAS 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:

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-E VI (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

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 gởi 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)*▼

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

○ **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 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Nếu nhiều hơn $63,940, xin điền tổng số vào đây $ __,___.00 mỗi năm

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

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

3

Quý vị có đồng ý với điều sau đây không? Xin đọc và ký bên dưới.

Tôi xin khai rõ rằng thông tin mà tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý sẽ cung cấp bằng cớ về việc hội đủ điều kiện theo chương trình CARE khi được yêu cầu. Tôi đồng ý báo cho SoCal Gas 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 SoCalGas 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 6491-2E, 06/14) T

(See Attached Form)

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

○ **NO** ▼

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, 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: / /

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FORM 6491-2E EN 0614 ♻ Printed on recycled paper with soy-based inks. N14J0014B XK

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 **socalgas.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
- Medi-Cal for 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 (Food Stamps)
- National School Lunch Program (NSLP)
- Low-Income Home Energy Assistance Program (LIHEAP)
- Supplemental Security Income (SSI)

MAXIMUM HOUSEHOLD INCOME:

(effective June 1, 2014 to May 31, 2015)

Number of Persons in Household	Total Annual Income*
1–2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180

For each additional household member, add $8,120

* 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

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 **socalgas.com/espanol** (busque la palabra clave *"CARE"*).

CÓMO CALIFICAR PARA EL DESCUENTO CARE:

PROGRAMAS DE ASISTENCIA PÚBLICA:

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

- Medi-Cal/Medicaid
- Medi-Cal para Familias A y B
- Programa para Mujeres, Bebés y Niños (WIC)
- CalWORKs (TANF)o TANF tribal
- Ingreso elegible para Head Start (tribal únicamente)
- Buró de Asistencia General para Asuntos de Nativos Americanos
- CalFresh (Estampillas para comida)
- Programa Nacional de Almuerzos Escolares (NSLP)
- Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- Ingreso Suplementario del Seguro Social (SSI)

← O →

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)

Número de personas en el hogar	Ingreso total anual*
1–2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Por cada miembro adicional en el hogar, añada $8,120	

* Incluye todas las fuentes de ingreso actual en el hogar antes de deducciones.

CONDICIONES PARA PARTICIPAR

La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal. 1. No debe aparecer como dependiente en la declaración de impuestos de otra persona que no sea su cónyuge. 2. Debe presentar su aplicacion nuevamente cuando se le solicite. 3. Debe notificar a SoCalGas en un plazo no mayor de 30 días si deja de reunir los requisitos para participar en el programa. 4. Tal vez se le pida que verifique su eligibilidad para el programa 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
- ○ Medi-Cal para Familias A y B
- ○ Programa para Mujeres, Bebés y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa Nacional de Almuerzos Escolares (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **NO** ▼

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, 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: / /

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♻ Impreso en papel reciclado con tintas a base de soya. N14J0014B XK

SAMPLE FORMS: APPLICATIONS
Post-Enrollment Verification CARE Application
Individually Metered Residential (Form 6675-E, 06/14) T

(See Attached Form)

A Sempra Energy utility®

Form 6675-E EN (06/14)

IMMEDIATE REPLY NEEDED

Dear Customer:

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

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

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

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

OR

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

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

FOR INFORMATION ON CARE, CALL SOCALGAS 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 Verification Form

Form 6675-E EN (06/14)

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
FAX: (213) 244-4665

Customer Name (as it appears on your bill):

Home Address (street, city, zip):

Account Number:

Phone Number: (   )   -

E-mail Address:

○ **I no longer qualify or wish to participate in CARE. Please remove my account from the CARE program.**
← *If you filled in this circle, please go directly to #4,* ***sign*** *at the bottom, and mail this form in the postage paid envelope provided within 90 days.*

(1) Total number of persons in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

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

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

Total Annual Household Income: If your household does not participate in any of the assistance programs from **List 1,** please fill in the circle (●) of your household's income range per year before deductions.

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, enter amount here: $ ___,___.00 per year

(3) ***YOU MUST PROVIDE PROOF THAT YOU QUALIFY FOR THIS PROGRAM***

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

○ Yes ○ No

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

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

FOR SOCALGAS USE ONLY:

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

INC: $

HH:

INITIALS:

Form 6675-E SP (06/14)

SE REQUIERE RESPUESTA INMEDIATA

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 Southern California Gas Company (SoCalGas®). Su hogar fue seleccionado al azar para verificar que reúne los requisitos. Para continuar recibiendo este descuento, sírvase devolver el formulario debidamente llenado y firmado, junto con la documentación requerida en el sobre provisto, o por fax, en un término de 90 días. Si no responde o se determina que no reunía los requisitos, tal vez reciba facturas con los montos corregidos.

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

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

Medicaid / Medi-Cal, Medi-Cal para familias A & B (Declaración de Prima Mensual)**, Programa para Mujeres, Bebés y Niños** (WIC)**, CalWORKs** (TANF) o **TANF Tribal, CalFresh** (Estampillas para Comida)**, Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía** (LIHEAP)**, Ingreso Suplementario del Seguro Social** (SSI)**, Programa Nacional de Almuerzos Escolares** (NSLP)**, Buró de Asistencia General para Asuntos de Nativos Americanos, Ingreso elegible para Head Start** (tribal únicamente)

O

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

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

PARA 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

Form 6675-E SP (06/14)

Verificación para la tarifa CARE del 20% de descuento

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

Por favor use tinta NEGRA y escriba claramente con letra de molde para asegurar el procesamiento apropiado
Forma correcta de marcar los círculos: ●

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

Domicilio particular:

Número de cuenta:

Teléfono: ( ) -

Correo electrónico:

○ **Ya no califico o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE.**
*←Si rellenó este círculo, por favor vaya directamente al número 4, **firme** en la parte de abajo, y envíe este formulario en el sobre con porte pagado provisto en un término de 90 días.*

(1) Número total de personas que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○si más de 6:

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

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

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

○ \$0 - \$31,460 ○ \$31,461 - \$39,580 ○ \$39,581 - \$47,700 ○ \$47,701 - \$55,820 ○ \$55,821 - \$63,940

○ Si es más de \$63,940, escriba el monto aquí: \$, .00 al año

DEBE PROPORCIONAR CONSTANCIA DE QUE REÚNE LOS REQUISITOS PARA ESTE PROGRAMA

(3) **Incluí** copias de la documentación que prueba la participación en un programa de asistencia (lista 1) **O** comprobante(s) de ingreso de cada miembro del hogar que recibe ingresos/ayuda (lista 2). Sírvase marcar el círculo (●).
○ Sí ○ No

(4) **DECLARACIÓN:** Por favor lea y firme abajo.
Declaro que la información y la documentación que proporcioné en este formulario de solicitud son verdaderas y correctas. Convengo en informar a 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**: / /

PARA USO EXCLUSIVO DE SOCALGAS:

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

INC: \$,

HH:

INITIALS:

Form 6675-E CH (06/14)

請立即答復

親愛的客戶：　　　　日期:

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

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

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

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

或

列表 2） 如果您家中無人參加上述任何計劃，**請您提供您家中每位成員的收入文件副本，包括所有收入和協助**。以下表格列出了收入來源和所需文件：

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

若需更多關于 CARE 計劃的資訊，請致電 SOCALGAS:

英語：1-800-427-2200　國語：1-800-427-1429　西班牙語：1-800-342-4545
韓語：1-800-427-0471　粵語：1-800-427-1420　越南語：　1-800-427-0478
聽覺障礙專綫 (TDD/TTY): 1-800-252-0259（僅提供英語和西班牙語服務）
（傳真）FAX: (213) 244-4665

CARE 計劃 20% 費率折扣確認表格

（請用深色筆以正楷填寫清晰以確保適當受理）

Form 6675-E CH (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
傳真(FAX): (213) 244-4665

客戶姓名：

地址：

帳戶號碼：

聯絡電話：(   )   -

電郵地址：

○ **我不再符合或不願再參加 CARE 計劃。請把我的賬戶從 CARE 計劃中取消。**
← *如果您將這個圓圈塗黑(●)，請直接填写第 4 部分，在文件下方**簽字**，將此表格放在所提供的郵資已付的信封中，在 90 天內寄回。*

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

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

	姓名	成人/兒童			姓名	成人/兒童	
1.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

家庭年收入總額: 如果您的家庭沒有參加**列表 1** 中的任何協助計劃，請您把能體現您家庭收入範圍的圓圈塗黑(●)。

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○如果多于 $63,940，請在此處填寫金額： $, .00 每年

(3) ***您必須提供證明您符合參加本計劃資格的資料***

我已經**附上**了能够證明參與協助計劃（列表 1）的文件副本**或**每個家庭成員的收入文件，包括接受的所有收入/協助（列表 2）。請塗黑符合您情况的圓圈(●)。

○ 是 ○ 否

(4) **聲明：**請您閱讀並簽字。

我聲明在此申請中提供的資料和文件均正確屬實。我同意若我不再符合條件時，即通知 SoCalGas。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 SoCalGas 可將有關我的資料提供給其它的公用事業公司或組織團體以協助我加入他們的協助計劃。

簽名：X **日期：** / /

僅供 SOCALGAS 填寫：

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

INC: $ HH: INITIALS:

Southern California Gas Company

A Sempra Energy utility®

Form 6675-E KO (06/14)

즉시 회신하셔야 합니다

친애하는 고객님: 날짜:

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

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

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

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

또는

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

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

CARE 에 대한 사항은 아래의 SOCALGAS 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

CARE 20% 요금 할인 확인 양식

Form 6675-E KO (06/14)

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

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

고객 이름:

주소:

구좌 번호:

주택 전화번호: ( ) -

이메일 주소:

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

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

○ 1　○ 2　○ 3　○ 4　○ 5　○ 6　○ 만약 6 개 이상:

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

	이름	성인 / 어린이			이름	성인 / 어린이	
1.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

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

○ $0 - $31,460　○ $31,461 - $39,580　○ $39,581 - $47,700　○ $47,701 - $55,820　○ $55,821 - $63,940

○ $63,940 을 초과하는 경우, 여기에 금액을 기입하십시오: 연간 $, .00

(3) ***귀하는 본 프 로그램 수혜 자격이 있다는 증명서류를 제출해야 합니다***
본인은 보조 프로그램(목록 1) 참여를 입증하는 문서 **또는** 소득 / 보조금(목록 2)을 받는 모든 식구에 대한 소득 문서의 사본을 **포함하였습니다.** 해당 동그라미(●)의 안을 채우십시오

○ 예　○ 아니오

(4) **진술:** 아래 사항을 읽고 서명하십시오.
본 신청서에서 본인이 제공한 정보와 문서가 정확한 사실이고 정확함을 진술합니다. 본인이 할인을 받을 자격이 더 이상 없게 될 경우 SoCalGas 에 통보하기로 동의합니다. 자격이 없으면서 할인을 받은 경우 받은 할인액을 환불해야 할 수도 있다는 것을 본인은 이해합니다. SoCalGas 에서 다른 유틸리티 회사나 에이전트의 지원 프로그램에 등록하기 위해 본인의 정보를 그들과 공유할 수 있다는 것을 본인은 이해합니다.

서명: **X**　　날짜: / /

SOCALGAS 에 한하여서만 사용 :

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

INC: $　HH:　INITIALS:

A Sempra Energy utility®

Form 6675-E VI (06/14)

CẦN HỒI ĐÁP NGAY

Kính Gởi Quý Khách Hàng: Ngày:

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

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

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

Medicaid, Medi-Cal, Gia đình Khỏe mạnh loại A&B (Bản kê Phí bảo hiểm Hàng tháng), 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 (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

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

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

ĐỂ BIẾT THÊM THÔNG TIN VỀ CHƯƠNG TRÌNH CARE, XIN GỌI SOCALGAS TẠI:

Tiếng Anh: 1-800-427-2200 Quan Thoại: 1-800-427-1429 Tây Ban Nha: 1-800-342-4545
Tiếng Hàn: 1-800-427-0471 Quảng Đông: 1-800-427-1420 Tiếng Việt: 1-800-427-0478

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

FAX: (213) 244-4665

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

Form 6675-E VI (06/14)

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

Bôi đen đúng cách: ●

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

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

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

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

	Tên	Người Lớn/Trẻ Em			Tên	Người Lớn/Trẻ Em	
1.		○	○	7.		○	○
2.		○	○	8.		○	○
3.		○	○	9.		○	○
4.		○	○	10.		○	○
5.		○	○	11.		○	○
6.		○	○	12.		○	○

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Nếu nhiều hơn $63,940, xin điền tổng số vào đây $ __,___.00 mỗi năm

(3) ***QUÝ VỊ PHẢI CUNG CẤP TÀI LIỆU CHỨNG MINH LÀ QUÝ VỊ HỘI ĐỦ ĐIỀU KIỆN THAM GIA CHƯƠNG TRÌNH NÀY***

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

○ Có ○ Không

(4) **LỜI KHAI:** Xin đọc và ký tên bên dưới.
Tôi xin khai rõ rằng thông tin và tài liệu tôi đã cung cấp trong đơn này là sự thật và chính xác. Tôi đồng ý báo cho SoCalGas 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 SoCalGas có thể chia sẻ thông tin của tôi với các hãng tiện ích khác hoặc các đại lý để ghi danh tôi vào các chương trình trợ giúp của họ.

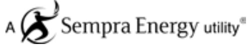
Chữ ký: X **Ngày:** __ / __ / __

PHẦN DÀNH RIÊNG CHO SOCALGAS:

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

INC: $ __,___ HH: __ INITIALS: ☐

SAMPLE FORMS: APPLICATIONS
Post-Enrollment Verification CARE Application
Sub-Metered Residential (Form 6675-ES, 06/14) T



Form 6675-ES EN (06/14)

IMMEDIATE REPLY NEEDED

Dear Tenant:

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

Required Documents: Please provide copies of document(s) from either list **1 OR 2** (not both).

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

Medicaid, Medi-Cal, Medi-Cal for Families A&B (Monthly Premium Statement), Women, Infants, & Children (WIC), CalWORKs(TANF), 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

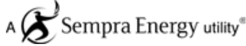
List 2) If no one in your household participates in any of the programs mentioned above, **please send copies of income documents for every household member receiving income or aid**. The chart below lists income sources and required documents:

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

FOR INFORMATION ON CARE, CALL SOCALGAS 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 Verification Form

Form 6675-ES EN (06/14)

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
FAX: (213) 244-4665

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 #4, **sign** at the bottom, and mail this form in the postage paid envelope provided within 90 days.*

(1) Total number of persons in your household: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ If more than 6: ☐

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

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

Total Annual Household Income: If your household does not participate in any of the assistance programs from **List 1,** please fill in the circle (●) of your household's income range per year before deductions.

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, enter amount here: $, .00 per year

(3) ***YOU MUST PROVIDE PROOF THAT YOU QUALIFY FOR THIS PROGRAM***
I have **included** copies of documentation proving participation in an assistance program (list 1) **OR** income document(s) for every household member receiving income/aid (list 2). Please fill in a circle (●).
○ Yes ○ No

(4) **DECLARATION:** Please read and sign below.
I state that the information and documents I have provided in this application are true and correct. 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**: / /

FOR SOCALGAS USE ONLY:
☐ 1 = CE 2 = INCOME 3 = BOTH
BLANK = INCOMPLETE
INC: $ HH: INITIALS:

Form 6675-ES SP (06/14)

SE REQUIERE RESPUESTA INMEDIATA

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 Southern California Gas Company (SoCalGas®). Su hogar fue seleccionado al azar para verificar que reúne los requisitos. Para continuar recibiendo este descuento, sírvase devolver el formulario debidamente llenado y firmado, junto con la documentación requerida en el sobre provisto, o por fax, en un término de 90 días. Si no responde o se determina que no reunía los requisitos, tal vez reciba facturas con los montos corregidos.

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

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

Medicaid / Medi-Cal, Medi-Cal para familias A & B (Declaración de Prima Mensual), **Programa para Mujeres, Bebés y Niños** (WIC), **CalWORKs** (TANF) o **TANF Tribal, CalFresh** (Estampillas para Comida), **Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía** (LIHEAP), **Ingreso Suplementario del Seguro Social** (SSI), **Programa Nacional de Almuerzos Escolares** (NSLP)**, Buró de Asistencia General para Asuntos de Nativos Americanos, Ingreso elegible para Head Start** (tribal únicamente)

O

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

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

PARA 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

Verificación para la tarifa CARE del 20% de descuento

Form 6675-ES SP (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

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

Forma correcta de marcar los círculos: ●

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

Domicilio particular:

No. de Facilidad:

Teléfono: ( ) -

Correo electrónico:

○ **Ya no califíco o no deseo participar en CARE. Sírvanse retirar mi cuenta del programa CARE.**
← *Si rellenó este círculo, por favor vaya directamente al número 4, **firme** en la parte de abajo, y envíe este formulario en el sobre con porte pagado provisto en un término de 90 días.*

(1) Número total de personas que viven en su hogar: ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○si más de 6:

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

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

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, escriba el monto aquí : $, .00 al año

DEBE PROPORCIONAR CONSTANCIA DE QUE REÚNE LOS REQUISITOS PARA ESTE PROGRAMA

(3) **Incluí** copias de la documentación que prueba la participación en un programa de asistencia (lista 1) **O** comprobante(s) de ingreso de cada miembro del hogar que recibe ingresos/ayuda (lista 2). Sírvase marcar el círculo (●).
○ Sí ○ No

(4) **DECLARACIÓN:** Por favor lea y firme abajo.
Declaro que la información y la documentación que proporcioné en este formulario de solicitud son verdaderas y correctas. Convengo en informar a 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**: / /

PARA USO EXCLUSIVO DE SOCALGAS:

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

INC: $,

HH:

INITIALS:

SAMPLE FORMS: APPLICATIONS
Self-Certification CARE Application
Submetered Residential (Form 6677-E, 06/14) T

(See Attached Form)

Form 6677-E EN (06/14)

20% CARE DISCOUNT APPLICATION

CALIFORNIA ALTERNATE RATES FOR ENERGY

Southern California Gas Company (SoCalGas®)'s California Alternate Rates for Energy (CARE) program provides a 20% discount on the monthly gas bill for eligible households. To see if you qualify, check the requirements shown below. Please complete the application and return it by mail or fax. Once your completed and signed application is approved by SoCalGas, 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
Medi-Cal for 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 (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2014 to May 31, 2015)
*current household income from all sources before deductions

Number of Persons in Household	Total Annual Income
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each additional person	+$8,120

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 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 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.

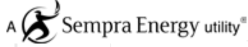
Medical Baseline: Provides additional allowance of gas at a lower rate to customers with certain medical conditions. For more information, call 1-800-427-2200.

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 CUSTOMER ASSISTANCE, CALL:

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



Form 6677-E EN (06/14)

CARE 20% Rate Discount Application

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

Tenant Name (as it appears on your bill):	
Home Address (street, space #, city, zip):	
Facility ID:	
Phone Number:	( ) -
E-mail Address:	

2

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

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

○ **YES** *(If yes, mark the program(s) of participation)*▼

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

○ **NO**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, enter amount here: $, .00 per year

Please mark your sources of income: ▼

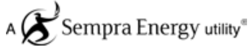
- ○ Social Security
- ○ SSP or SSDI
- ○ Pensions
- ○ Interest or Dividends from: Savings, Stocks, Bonds, or Retirement Accounts
- ○ Wages and/or Profit from Self Employment
- ○ Unemployment Benefits
- ○ Insurance or Legal Settlements
- ○ Disability or Workers Compensation Payments
- ○ Spousal or Child 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 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**: / /



Form 6677-E SP (06/14)

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 Southern California Gas Company (SoCalGas®) 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 SoCalGas, 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 socalgas.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
Medi-Cal Para Familias A & B
Programa para Mujeres, Bebés y Niños (WIC)
CalWORKs (TANF) o TANF Tribal
CalFresh (Estampillas para Comida)
Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa Nacional de Almuerzos Escolares (NSLP)
Buró de Asistencia General para Asuntos de Nativos Americanos
Ingreso elegible para Head Start (tribal únicamente)

o

INGRESO MÁXIMO EN EL HOGAR:

(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

Número de personas en el hogar	Ingreso total anual
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Cada persona adicional	+$8,120

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 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: 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
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-E SP (06/14)

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:	
Teléfono:	( ) -
E-mail:	

2

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

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

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

- ○ Medi-Cal / Medicaid: menor de 65 años
- ○ Medi-Cal / Medicaid: 65 años o más
- ○ Medi-Cal para familias A & B
- ○ Programa para Mujeres, Bebés, y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para Comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa Nacional de Almuerzos Escolares (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **No**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, 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

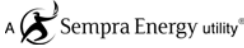
¿Acepta usted lo siguiente? Por favor lea y firme abajo.

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-Recertification CARE Application
Submetered Residential (Form 6678-E, 06/14) T

(See Attached Form)



Form 6678-E EN (06/14)

YOUR RATE DISCOUNT IS EXPIRING

Dear Tenant:

You are currently receiving a 20% rate discount on your monthly gas bill through Southern California Gas Company (SoCalGas®)'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. 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

2. Visit our Website http://www.socalgas.com/care/recert/ and have your facility ID ready.

OR

3. Return your completed and signed by mail or fax,

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
Medi-Cal for 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 (Food Stamps)
National School Lunch Program (NSLP)
Low Income Home Energy Assistance Program
Supplemental Security Income (SSI)

OR

MAXIMUM HOUSEHOLD INCOME*:
(effective June 1, 2014 to May 31, 2015)
*current household income from all sources before deductions

Number of Persons in Household	Total Annual Income
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Each Additional Person	+$8,120

CONDITIONS FOR PARTICIPATION

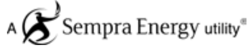
- This address must be your primary address.
- You must not be claimed as a dependent on another person's income tax return other than your spouse.
- You must recertify your application when requested.
- You must notify SoCalGas within 30 days if you no longer qualify.
- You may be asked to verify your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

FOR INFORMATION ON CARE, CALL SOCALGAS 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

Form 6678-E EN (06/14)

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
FAX: (213) 244-4665

1

Tenant Name (as it appears on your bill):

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

Facility ID:

Phone Number: ( ) -

E-mail Address:

○ **I no longer qualify or wish to participate in CARE. Please remove my account from the CARE program.**
← *If you filled in this circle, please go directly to #3,* ***sign*** *at the bottom, and mail this form in the postage paid envelope provided within 90 days.*

2

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

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

○ **YES** *(If yes, mark the program(s) of participation)*▼

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

○ **NO**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, 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 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:** / /

Form 6678-E SP (06/14)

EL DESCUENTO EN SU TARIFA ESTÁ POR VENCER

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 Southern California Gas Company (SoCalGas®). 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. 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,

O

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

O

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

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
Medi-Cal Para Familias A & B
Programa para Mujeres, Bebés y Niños (WIC)
CalWORKs (TANF) o TANF Tribal
CalFresh (Estampillas para Comida)
Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
Ingreso Suplementario del Seguro Social (SSI)
Programa Nacional de Almuerzos Escolares (NSLP)
Buró de Asistencia General para Asuntos de Nativos Americanos
Ingreso elegible para Head Start (tribal únicamente)

O

INGRESO MÁXIMO EN EL HOGAR:
(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)
*ingreso actual en el hogar de todas las fuentes antes de deducciones

Número de personas en el hogar	Ingreso total anual
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180
Cada persona adicional	+$8,120

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 SoCalGas en un término de 30 días si deja de calificar. / Tal vez se le pida comprobar que reúne los requisitos para CARE.

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

Número de complejo habitacional (*Facility ID)*:

A Sempra Energy utility®

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

Form 6678-E SP (06/14)

CARE PROGRAM ML GT19A1
PO BOX 3249
LOS ANGELES, CA 90051-1249
FAX: (213) 244-4665

Por favor use tinta NEGRA 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
- ○ Medi-Cal Para Familias A & B
- ○ Programa para Mujeres, Bebés, y Niños (WIC)
- ○ CalWORKs (TANF) o TANF Tribal
- ○ CalFresh (Estampillas para Comida)
- ○ Programa de Asistencia a Hogares de Ingresos Limitados para Gastos de Energía (LIHEAP)
- ○ Ingreso Suplementario del Seguro Social (SSI)
- ○ Programa Nacional de Almuerzos Escolares (NSLP)
- ○ Buró de Asistencia General para Asuntos de Nativos Americanos
- ○ Ingreso elegible para Head Start (tribal únicamente)

○ **No**

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

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ Si es más de $63,940, 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

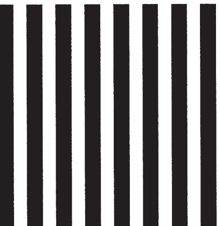
¿Acepta usted lo siguiente? Por favor lea y firme abajo.

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** : / /

APPLICATION FOR CALIFORNIA ALTERNATE RATES
FOR ENERGY PROGRAM - BILL INSERT
(Form 6491-BI, 06/14) T

(See Attached Form)



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UNITED STATES

Southern California Gas Company

A Sempra Energy utility®

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/ESPANOL
(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 **socalgas.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) descuento(s) una vez que su solicitud sea aprobada por SoCalGas. Si tiene alguna duda acerca de la solicitud, visite **socalgas.com/espanol** (busque la palabra clave *"ASISTENCIA"*) o llame al 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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HOW TO QUALIFY / COMO PUEDE CALIFICAR

1 PUBLIC ASSISTANCE PROGRAMS
PROGRAMAS DE ASISTENCIA PÚBLICA

If you or another person in your household receives benefits from any of the following programs:
Si usted u otra persona que vive en su hogar recibe beneficios de cualquiera de los siguientes programas:

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

←OR/O→

2 MAXIMUM HOUSEHOLD INCOME
INGRESO MÁXIMO EN EL HOGAR:

(effective June 1, 2014 to May 31, 2015)
(en vigor del 1 de junio de 2014 al 31 de mayo de 2015)

Number of Persons in Household / Número de personas en el hogar	Total Annual Income* / Ingreso total anual*
1-2	$31,460
3	$39,580
4	$47,700
5	$55,820
6	$63,940
7	$72,060
8	$80,180

For each additional household member, add $8,120
Por cada miembro adicional en el hogar, añada $8,120

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

CONDITIONS FOR PARTICIPATION / CONDICIONES PARA PARTICIPAR

1) The gas bill must be in your name and the address must be your primary address. / La factura de gas debe estar a su nombre y la dirección debe ser su domicilio principal. **2)** You must not be claimed as a dependent on another person's income tax return other than your spouse. / No debe aparecer como dependiente en la declaración de impuestos sobre el ingreso de otra persona que no sea su cónyuge. **3)** You must recertify your application when requested. / Debe recertificar su solicitud cuando se le solicite. **4)** You must notify SoCalGas within 30 days if you no longer qualify. / Debe notificar a SoCalGas en un término de 30 días si deja de calificar. **5)** You may be asked to verify your eligibility for CARE. / Tal vez se le pida comprobar que reúne los requisitos para CARE.

FORM 9E

CARE APPLICATION /
SOLICITUD PARA EL PROGRAMA CARE

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

ACCOUNT NO./ NO. DE CUENTA ☐☐☐ ☐☐☐ ☐☐☐☐ ■
Please provide your account number to expedite processing./ Por favor proporcione su número de cuenta para facilitar procesamiento.

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

ADDRESS/DOMICILIO — APT #/NO. DE APTO.

CITY/CIUDAD — HOME PHONE/TELÉFONO DE SU CASA ☐☐☐ - ☐☐☐ - ☐☐☐☐

EMAIL/CORREO ELECTRÓNICO:

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

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

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

○ **YES (If yes, please fill in the circle(s) ●)/**
SÍ (Si su respuesta es afirmativa, por favor rellene el/los círculo/s ●).

- ○ Medi-Cal / Medicaid: Under Age 65/menor de 65 años
- ○ Medi-Cal / Medicaid: 65 or older/65 años o más
- ○ Medi-Cal for Families A&B
- ○ Women, Infants, and Children Program (WIC)
- ○ CalWORKs (TANF) or Tribal TANF
- ○ CalFresh (Food Stamps / Estampillas para comida)
- ○ Low-Income Home Energy Assistance Program (LIHEAP)
- ○ Supplemental Security Income (SSI)
- ○ National School Lunch Program (NSLP)
- ○ Bureau of Indian Affairs General Assistance
- ○ Head Start Income Eligible - Tribal Only/Solamente tribal

○ **NO**
NO

What is your yearly household income (before deductions, including all members of the household)? /
¿Cual es el ingreso anual de su hogar (antes de deducciones, incluyendo a todos miembros del hogar)?

○ $0 - $31,460 ○ $31,461 - $39,580 ○ $39,581 - $47,700 ○ $47,701 - $55,820 ○ $55,821 - $63,940

○ If more than $63,940, enter the dollar amount here/Si es más de $$63,940, escriba el monto aquí: $☐☐,☐☐☐.00 per year/al año

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

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

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

I state that the information I have provided in this application is true and correct. I agree to provide proof of CARE eligibility if asked. I agree to inform SoCalGas if I no longer qualify to receive a discount. I understand that if I receive the discount without qualifying for it, I may be required to pay back the discount I received. I understand that SoCalGas can share my information with other utilities or agents to enroll me in their assistance programs. / Declaro que la información que proporcioné en este formulario de solicitud es verdadera y correcta. Convengo en proporcionar prueba de elegibilidad en el programa CARE si se me requiere. Convengo en informar a 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 programas de asistencia.

SIGNATURE/ FIRMA X ______ DATE/ FECHA ☐☐ / ☐☐ / ☐☐

FORM 6491-BI 0614

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

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