

# 20% DISCOUNT

# CARE APPLICATION

The California Alternate Rates for Energy (CARE) program offers eligible SoCalGas® customers a 20% discount on their monthly natural gas bill. The discount will be applied to the monthly bill following the date that the application is approved by SoCalGas.

## Please submit a completed application by using one of the methods listed below:

- 1) Visit [myaccount.socalgas.com](https://myaccount.socalgas.com) or [socalgas.com/CARE](https://socalgas.com/CARE). Your request will be processed promptly.
- 2) Call 1-866-716-3452 anytime, 24 hours a day. Please have your account number ready.
- 3) Return the completed and signed form by mail or fax to (213) 244-4665.

## There are TWO ways to qualify:

### Public Assistance Programs

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

- Medi-Cal/Medicaid
- Medi-Cal for Families A&B
- Women, Infants & Children (WIC)
- CalWORKs (TANF)<sup>1</sup> 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

<sup>1</sup>Includes Welfare-To-Work

← OR →

### Maximum household income

effective June 1, 2024 to May 31, 2025

 Number of persons in household	1-2	\$40,880	 Total annual income*
	3	\$51,640	
	4	\$62,400	
	5	\$73,160	
	6	\$83,920	
	7	\$94,680	
	8	\$105,440	

Each additional person +\$10,760

\*Current household income from all sources before deductions.

## Conditions for participation:

1) You must meet the qualification requirements in the table above. 2) The natural gas bill must be in your name and the address must be your primary address. 3) You must not be claimed as a dependent on another person's income tax return other than your spouse. 4) You must recertify your application when requested. 5) You must notify SoCalGas within 30 days if you no longer qualify. 6) You may be asked to verify your eligibility for CARE.

## Other programs and services you may qualify for:



### Help for your home

Energy-saving home improvements from authorized local contractors at no cost.

Energy Savings  
Assistance Program

[socalgas.com/Improvements](https://socalgas.com/Improvements)  
1-800-331-7593

### Help for medical needs



Medical Baseline Allowance Program offers additional natural gas at the lowest baseline rate for those with qualifying medical conditions.

[socalgas.com/Medical](https://socalgas.com/Medical) 1-866-431-3517

### Help with your bill

#### Low Income Home Energy Assistance

Utility bill assistance and weatherization services.  
1-866-675-6623

#### Arrearage Management Plan

Past due bill forgiveness for qualified customers  
[socalgas.com/Forgiveness](https://socalgas.com/Forgiveness) 1-800-427-2200

### Help with your phone



#### California Lifeline

Discounted telephone services for eligible customers.  
[californialifeline.com](https://californialifeline.com)

English: 1-800-427-2200

廣東話: 1-800-427-1420

FAX: (213) 244-4665

한국어: 1-800-427-0471

Español: 1-800-342-4545

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

中文: 1-800-427-1429

Việt: 1-800-427-0478



[socalgas.com](https://socalgas.com)

1 (800) 427-2200

# 20% DISCOUNT CARE APPLICATION

Please use dark blue or black ink only.

Please complete and return this application by mail, fax, or apply online at [socialgas.com/CARE](https://socialgas.com/CARE).

**MAIL TO:** SoCalGas CARE Program, P.O. Box 3249, Los Angeles, CA 90051-1249 or Fax to: (213) 244-4665

ACCOUNT NUMBER

Please provide the first 10 digits of your account number.

CUSTOMER NAME (FIRST AND LAST AS IT APPEARS ON YOUR BILL)

ADDRESS

APT/SPACE #

CITY

PRIMARY PHONE

**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, please fill in the circle(s) ●)**
- 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
  - 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
- NO (If no, what is your yearly household income before deductions, including all members of the household?)**
- \$0 - \$40,880
  - \$40,881 - \$51,640
  - \$51,641 - \$62,400
  - \$62,401 - \$73,160
  - \$73,161 - \$83,920
  - If more than \$83,920, 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 salary
- 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, other income, or profit from self-employment

**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 program eligibility if asked. I agree to inform SoCalGas within 30 days if I no longer qualify to receive a discount. I understand that if I receive the discount without qualifying for it, I am required to pay back the discount I received. I authorize SoCalGas to share my information in order to remain eligible for available energy management assistance, and price reduction and residential rate programs with other utilities, state agencies and entities designated by the CPUC.

SIGNATURE: X

DATE:  /  /