



Central Coast Energy Services

California's Low-Income Rate Assistance
Programs

www.EnergyServices.org

California Alternate Rates for Energy (CARE/FERA)



The CARE program is a discount-rate program offered by PG&E which provides eligible low-income households with a 20% discount on utility bills for 2 years.

New income guidelines make it easier to qualify for monthly discounts on your energy bill. No proof of income needed to enroll. Can apply online:

https://m.pge.com/?_ga=2.85996061.407625575.1607362188-724610951.1606257071#login



CARE applicants are encouraged to apply for the LIHEAP benefit as well!

PG&E CARE/FERA PROGRAM APPLICATION Residential Customers Form 01-9077

Please fill out the information below about you and your household, and then the information for EITHER Section 2A OR 2B. Sign and date this form and return it to PG&E as soon as possible. If you qualify, your CARE or FERA discount will appear on the first page of your next PG&E bill.

1 You and Your Household

Your PG&E Account Number (Find yours on page 1 of your PG&E bill.)

Your Name (Use the name as it appears on your PG&E bill, which must be in your name.)

Your Home Address (Address must be your primary residence. Do NOT use a P.O. Box.) Unit #

City/State/Zip Code

Email Address (By entering your email address, you are authorizing PG&E to send you information from time to time regarding your PG&E utility service and PG&E programs and services that may be available to you.)

Preferred Phone Number Home Work Mobile

Alternative Phone Number Home Work Mobile

Number of people in your household at this address:
Adults + Children =
(under 18)

What language do you prefer for future CARE and FERA communications? (Choose one)
 English Spanish Mandarin Cantonese Vietnamese
 Russian Korean Tagalog Hmong

What is your preferred method of communication? (Choose one)
 Mail Email Phone Text (Message and data rates may apply)

2 Household Qualification

Fill out Section 2A OR Section 2B. You do not need to complete both sections. You will be enrolled in either the CARE or the FERA Program, depending on your household income and household size.

2A Public Assistance Programs
Check all the programs in which you, or someone in your household, participate.

Low Income Home Energy Assistance Program (LIHEAP) Medi-Cal for Families (Healthy Families A&B)
 National School Lunch Program (NSLP)
 Women, Infants, and Children (WIC) Bureau of Indian Affairs General Assistance
 CalFresh/SNAP (Food stamps) Medicaid/Medi-Cal (under age 65)
 CalWORKs (TANF) or Tribal TANF Medicaid/Medi-Cal (age 65 and over)
 Head Start Income Eligible (Tribal only) Supplemental Security Income (SSI)

If you checked any of the boxes in this section, skip to Section 3.

2B Household Income
If you did not check any of the boxes in Section 2A, please add up all the income from every household member and check the box below that matches your household's total annual gross income. Please note: The income ranges listed below ARE NOT fixed incremental amounts, so carefully review each income range before selecting the appropriate box.

I am currently on a fixed income and receive income or benefits from one or more of the following: pensions, Social Security, SSP or SSDI, interest/dividends from retirement accounts, Medicaid/Medi-Cal (age 65 and over) or SSI.

My household income is:

<input type="checkbox"/> \$0-\$32,040	<input type="checkbox"/> \$60,751-\$65,160	<input type="checkbox"/> \$81,781-\$90,100
<input type="checkbox"/> \$32,041-\$40,320	<input type="checkbox"/> \$65,161-\$71,100	<input type="checkbox"/> \$90,101-\$91,825
<input type="checkbox"/> \$40,321-\$48,600	<input type="checkbox"/> \$71,101-\$73,440	<input type="checkbox"/> \$91,826-\$98,420
<input type="checkbox"/> \$48,601-\$50,400	<input type="checkbox"/> \$73,441-\$81,450	<input type="checkbox"/> \$98,421-\$102,225
<input type="checkbox"/> \$50,401-\$56,880	<input type="checkbox"/> \$81,451-\$81,780	<input type="checkbox"/> Other \$ _____
<input type="checkbox"/> \$56,881-\$60,750		

3 Your Declaration

By signing this declaration, I certify that based on my household size and income I qualify for either the CARE or the FERA Program.

I acknowledge that I have read and understood the contents of this application, and will have the opportunity to ask questions at any time.

I also agree to the following program terms and conditions in order to remain eligible for the CARE or the FERA Program:

- I will notify PG&E if my household is no longer eligible for the CARE or FERA discount.
- I understand I may be required to provide proof of household income and to participate in the Energy Savings Assistance Program.
- I will allow PG&E to share my information with other utilities or their agents, for the sole purpose of facilitating enrollment in their assistance programs.
- I will pay back the discount if any of the information provided above is untrue.
- The information I have provided here is true and correct.

X Customer Signature
 Fill in circle if you are a guardian or you have power of attorney.

Date FOR INTERNAL USE ONLY
111

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Medical Baseline Application



The medical baseline/life support is an allowance billed at the lowest rate for customers who rely on life support equipment.

This includes: § All types of respirators, iron lungs, hemodialysis machines, suction machines, electric nerve stimulators, pressure pads and pumps, aerosol tents, electrostatic and ultrasonic nebulizers, compressors, IPBB machines and motorized wheelchairs.

Due to COVID-19, a signature from a qualified medical practitioner is not required. Can apply online:

https://www.pge.com/en_US/residential/save-energy-money/help-paying-your-bill/longer-term-assistance/medical-condition-related/medical-baseline-allowance/medical-baseline-covid19.page

Medical Baseline Program Application—Part A (To be completed by customer) For Medical Baseline Program Enrollment and Recertification

STEP 1 Account and Customer Information (Please print.)

PG&E CUSTOMER ACCOUNT NO.

CUSTOMER NAME (as it appears on PG&E bill)

MEDICAL BASELINE RESIDENT'S NAME (if different than customer name)

SERVICE ADDRESS APT #

CITY STATE ZIP CODE

CUSTOMER MAILING ADDRESS (if different than service address) APT #

CITY STATE ZIP CODE

HOME PHONE # WORK PHONE #

STEP 2 For customers billed by someone other than PG&E

NAME OF MOBILE HOME OR APARTMENT COMPLEX

COMPLEX ADDRESS

COMPLEX MANAGER'S NAME COMPLEX PHONE #

TENANT'S NAME TENANT'S PHONE #

STEP 3 Contact preferences for outages or other Medical Baseline communications (Check all that apply.)

Please make sure PG&E has your correct contact preferences so we can reach you in advance of a planned public safety power shutoff (PSPS) or other situations that may result in an outage. In certain situations, we may also send a letter. All contact methods will be used during a PSPS event.

CONTACT PREFERENCES

Call phone number 1: _____

Call phone number 2: _____

Text mobile number 1: _____

Text mobile number 2: _____

Email 1: _____

Email 2: _____

Contact by TTY at phone number: _____

I understand and agree that:

- If the qualified medical practitioner certifies the resident's medical condition is permanent, PG&E requires completion of a form every two years self-certifying the resident's continued eligibility for the Medical Baseline Program.
- If the qualified medical practitioner certifies the resident's medical condition is not permanent, PG&E requires completion of a form every year self-certifying the resident's continued eligibility for the Medical Baseline Program and completion of a new application including a qualified medical practitioner's certification every two years.
- Residents with a vision disability may contact PG&E to request special notification when notices are sent for either recertification (completion of a new application including a qualified medical practitioner certification) or self-certification.
- PG&E cannot guarantee uninterrupted gas and electric service. I am responsible for making alternate arrangements in the event of a gas or an electric outage.
- Both Part A and Part B of this form must be completed and submitted to PG&E, online or by mail, prior to PG&E processing the application.
- Customers may also benefit from energy savings programs such as Energy Upgrade California® Home Upgrade. The Energy Savings Assistance Program for income-qualified customers, provides improvements at no charge. For more information, please visit pge.com/saveenergy.
- PG&E may share my contact information with organizations such as state and local emergency first response agencies, so that they can provide assistance to PG&E and to me personally during an extended outage to support my safety and well-being.
- The standard Medical Baseline allowance provides extra energy at the lowest price. Medical Baseline allowances are added to your standard rate plan baseline allocation. For electricity, it is 16.438 kWh per day (approx. 500 kWh per month), an additional amount equal to the daily consumption of an average electric household. For gas, it is 0.82192 therms per day (approx. 25 therms per month), an additional amount equal to three-quarters of the daily consumption of an average gas household. **If these Medical Baseline allowances do not meet your medical energy needs, please contact PG&E at 1-800-743-5000.** More information about the Medical Baseline Program can be found at pge.com/medicalbaseline.

STEP 4 Signature

I certify the above information is correct. I also certify the Medical Baseline resident lives full-time at this address and requires the Medical Baseline Program. I agree to allow PG&E to verify this information. I also agree to notify PG&E promptly if the qualified resident moves or the resident no longer needs the Medical Baseline Program.

SIGN

CUSTOMER SIGNATURE _____

DATE _____

Automated Document, Preliminary Statement, Part A