



Southern California Edison  
Rosemead, California (U 338-E)

Revised Cal. PUC Sheet No. 71123-E  
Cancelling Revised Cal. PUC Sheet No. 70550-E

Sheet 1

CALIFORNIA ALTERNATE RATES FOR ENERGY  
APPLICATION FOR QUALIFIED NONPROFIT  
GROUP LIVING FACILITIES

Form 14-526

(To be inserted by utility)

Advice 4479-E  
Decision 04-02-057; 12-08-044

Issued by

Carla Peterman  
Senior Vice President

(To be inserted by Cal. PUC)

Date Submitted Apr 28, 2021  
Effective Jun 1, 2021  
Resolution E-3524

**FACILITIES WITH SATELLITE LOCATIONS**

If a qualifying facility has one or more satellite locations, these satellite locations will qualify for the discount providing they are covered by the qualifying facility's license, the qualifying facility's name is on the satellites' utility bills, and they meet all of the same criteria listed for the qualifying facility.

The qualifying facility must complete the following information for all qualified satellite facilities. Satellite facilities do not need to apply for the discount individually. List satellite facilities:

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

STREET ADDRESS \_\_\_\_\_  
 CITY STATE ZIP \_\_\_\_\_  
 ACCOUNT NO \_\_\_\_\_  
 At least 70% of electricity used for residential purposes?  Yes  No  
 100% of the residents individually meet the income criteria?  Yes  No  
 Number of residents: \_\_\_\_\_  
 For Homeless Shelters – Is facility open 180 days or more annually?  Yes  No  
 – Does shelter have six beds or more?  Yes  No

Attach list of additional locations if necessary. Please provide information in the same format as above.

I am responsible for the annual renewal of this facility's license from the appropriate licensing agency.

I certify under penalty of perjury under the laws of the State of California the information on this application is true and accurate.

I further certify the discount received will be used for the direct benefit of the residents of the facility.

I understand Edison reserves the right to verify the accuracy of this information and that the direct benefit was used for the benefit of the residents.

My signature gives consent for this information to be shared with other utilities or their agents, if applicable.

AUTHORIZED REPRESENTATIVE'S NAME (Please Print) \_\_\_\_\_  
 AUTHORIZED REPRESENTATIVE'S TITLE (Please Print) \_\_\_\_\_  
 AUTHORIZED REPRESENTATIVE'S SIGNATURE \_\_\_\_\_  
 DATE \_\_\_\_\_  
 TELEPHONE NUMBER \_\_\_\_\_



# California Alternate Rates for Energy (CARE)

## Application for Qualified Nonprofit Group Living Facilities

### INSTRUCTIONS

1. READ ALL information and instructions.
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 discount from CARE.
3. COMPLETE the entire application (please print or type).
4. Complete a separate application for each facility. If a qualifying facility has satellite facilities, please provide the information requested for each satellite location.
5. ATTACH all required documents. (Application is not considered complete without documents.)
6. MAIL TO: Southern California Edison Company  
 California Alternate Rates for Energy  
 P. O. Box 9527  
 Azusa, CA 91702-9954

### Discount

Your facility may qualify for a discount off of your Edison bill if the facility meets the following criteria. Please see applicable rate schedule for more information. The discount and eligibility criteria were established by the California Public Utilities Commission (CPUC).

#### FACILITY ELIGIBILITY CRITERIA

- The facility MUST meet ALL of the following criteria:
- Corporation operating the facility must have tax exemption under IRS Code 501(c)(3).
  - A minimum of 70% of the energy consumed at the facility must be for residential purposes.
  - Facility will be required to recertify eligibility annually. As part of that process, facility will be required to estimate amount of discount received, and explain how the funds were used for direct benefit of the residents.



(continued)

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**Additional Criteria for Group Living Facilities Such As Transitional Housing; Short- or Long-Term Care Facilities; or Group Homes for Physically or Mentally Disabled Persons**

- If facility is licensed by organizations such as the Community Care Licensing Division (CCLD) of the State Department of Social Services, the Licensing Branch of the Department of Alcohol and Drug Programs, or the Department of Health Services, a copy of the license must be provided.
- If facility does not have a conditional use permit or an appropriate state license, facility must provide satisfactory proof to the utility it is eligible to participate in CARE.
- Facility must provide services, such as meals or rehabilitation, in addition to lodging.
- 100 percent of the residents must individually meet the CPUC's existing income eligibility criteria for a single-person household (see section on RESIDENTS' ELIGIBILITY CRITERIA).
- Satellite facilities of a qualifying nonprofit corporation, must be included under the corporation's license, meet all eligibility criteria, and have utility accounts in the corporation name.

**Additional Criteria for Homeless Shelters, Hospices, and Women's Shelters**

- Facility must provide a minimum of six beds each night for a minimum of 180 days each year for persons who have no alternative residence.
- Primary function of the facility is to provide lodging.
- Facility may be asked to provide appropriate documentation indicating primary function.

**FACILITIES NOT ELIGIBLE**

- Group living facilities offering only a place to live.
- Government-owned and/or operated facilities.
- Government-subsidized facility providing lodging only.

**RESIDENTS' ELIGIBILITY CRITERIA Effective as of June 1, 2021**

- Each resident's total annual income from all sources, taxable and nontaxable, cannot exceed \$34,840.
- No resident may be claimed as a dependent on someone else's income tax return.

**ATTACHMENTS REQUIRED**

The following items MUST be attached to the application:

**For Group Living Facilities**

- A copy of the IRS documentation approving tax exempt status, under Code 501(c)(3), for the corporation operating the facility.
- A copy of the facility's license from the licensing agency if facility has a license.
- If the facility does not have a license, satisfactory proof to the utility that the facility is eligible to participate in the program.

**For Homeless Shelters, Hospices, and Women's Shelters**

- A copy of the IRS documentation approving tax exempt status under Code 501(c)(3), for the corporation operating the facility.

**IF YOU HAVE QUESTIONS**

Call Edison's CARE Helpline at 1-800-447-6620

**California Alternate Rates for Energy (CARE) Application for Qualified Nonprofit Group Living Facilities**



**For Office Use Only**

Received Date \_\_\_\_\_ Process Date \_\_\_\_\_  
Denied Reason \_\_\_\_\_ By \_\_\_\_\_

Source Code (Edison Use Only)     -

Please complete a separate application for each facility.

Name on Edison Bill \_\_\_\_\_

Name of Business/Facility \_\_\_\_\_

Service Address \_\_\_\_\_  
STREET CITY STATE ZIP

Mailing Address (if different) \_\_\_\_\_  
STREET CITY STATE ZIP

Service Account number(s) for this facility \_\_\_\_\_  
(Attach list if necessary)

If a qualifying facility has satellite locations, please provide the information requested on the other side of this application for each location.

- Is facility operated by a corporation with tax exempt status under IRS Code 501(c)(3)? (attach documentation) . . . . .  Yes  No
- Is facility government owned and/or operated? . . . . .  Yes  No
- Is facility government subsidized housing? . . . . .  Yes  No
- Is at least 70% of the facility's electricity used for residential purposes? . . . . .  Yes  No
- Recertification: Estimated amount of discount received last year \$ \_\_\_\_\_
- What was discount used for? \_\_\_\_\_

**For Group Living Facilities Only**  
Primary Purpose of Facility \_\_\_\_\_  
Services Offered \_\_\_\_\_  
Total Number of Residents of Facility \_\_\_\_\_

**For Homeless Shelters Only**  
Is facility open 180 days or more annually? . . . . .  Yes  No  
How many beds does shelter have? . . . . . \_\_\_\_\_

I have verified 100% of the residents of the facility individually meet the CPUC's CARE Eligibility Criteria for a Single Person Household . . . . .  Yes  No  
Is the facility licensed by an authorized agency? . . . . .  Yes  No  
Name of Licensing Agency (Copy of license required) \_\_\_\_\_