

California Alternate Rates for Energy (CARE) Capitation Fee Program Organization Application Form

Date: _____
 Organization Name: _____
 Street Address: _____
 City, State ZIP: _____
 Website: _____
 How did you hear about the SCE Capitation Program?: _____

Contact Information

Executive Contact: _____	Phone : _____
Email Address: _____	Fax : _____
Administrative Contact: _____	Phone : _____
Email Address: _____	Fax : _____

Please provide two (2) professional references who can be contacted by SCE:

Name: _____	Name: _____
Company: _____	Company: _____
Phone: _____	Phone: _____

Capitation Program Information

Please indicate the cities where your organization will be conducting CARE outreach: _____

Please provide your organization's operating days/hours: _____

How many CARE applications does your organization expect to submit per month?: _____

Is your organization a LIHEAP provider? Yes No

Is your organization a So Cal Gas CARE Capitation contractor?: Yes No

All capitation agencies must submit IRS Form W-9, CA 590 Form, proof of tax exempt status, and proof of WMDVBE certification (if applicable)

Organization Information

Is your organization women, minority, disabled veteran business enterprise (WMDVBE) Certified?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Does your organization identify as a faith-based organization?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
What is the tax status of your organization?:	For-Profit <input type="checkbox"/>	Non-Profit <input type="checkbox"/>	Does your organization conduct income Verification for other low income programs?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is your organization a corporation?:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	How long has your organization provided services to the community?:	_____	

Please describe the services provided by your organization: _____

What languages, other than English, do you provide services?

Spanish: Chinese: Korean: Vietnamese: Cambodian:

Other: _____

What is your organization's target population? Please check all applicable groups. Specify under "other" if not listed.

Seniors: <input type="checkbox"/>	Disabled: <input type="checkbox"/>	Ethnic Group: _____
Veterans: <input type="checkbox"/>	Children: <input type="checkbox"/>	Other: _____
Women: <input type="checkbox"/>	Homeless: <input type="checkbox"/>	_____

**Please return this application via Email to CAREandFERACap@sce.com or Mail to:
SCE CARE Capitation Manager, 1515 Walnut Grove Ave., 2nd Floor, Rosemead, CA 91770**

Please allow four weeks for processing. The capitation fee is intended to cover the cost to assist clients in completing the CARE Application.