# Pacific Power CARE Program Application

Mail completed forms to: CARE Program Manager
Pacific Power
825 NE Multnomah, Suite 800
Portland, OR 97232

For questions call: 1-888-221-7070

**Pacific Power customer information:** (All information is required. Please print clearly.)

**Account number:** You can find this in the upper right hand corner of your Pacific Power bill.

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**Name:** (As it appears on your Pacific Power bill)

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**Home address:** (No P.O. Boxes)

_____ **City:** _____ **Zip code:** _____

**Mailing address:** (If different than your home address)

_____ **City:** _____ **Zip code:** _____

**Daytime telephone number including area code:** __ __ __ - __ __ __ - __ __ __ __

**Number of people in your household:** _____ + _____ = _____

**Adults** **Children** **Total**

The following chart illustrates monthly income levels that qualify for the CARE program. Look at the income allowable for the number of people in your household.

| Number in Household | Monthly Income at or Below |
|---|---|
| 1 or 2 | $2,225 |
| 3 | $2,608 |
| 4 | $3,150 |
| 5 | $3,692 |
| 6 | $4,233 |
| 7 and more | For households with more than 6 people, add $542 for each additional individual to determine allowable income level. |

Applicants must add all sources of the household's combined income to determine eligibility. These sources include wages and salaries, interest and dividends from savings accounts/stocks/bonds/retirement accounts, unemployment benefits, rental and royalty income, school grants and scholarships, profit from self-employment, disability payments, workers compensation, Social Security (SSI, SSP), pensions, insurance and legal settlements, TANF (AFDC), food stamps, child support, spousal support, cash and other income.

**Please read carefully and sign below.**

I state that my total combined household income is no greater than the amount shown above for the number of members in my household.* I agree to provide proof of income if asked. I agree to inform Pacific Power if my income no longer qualifies and I may be required to pay back CARE benefits received.

**X**_____ _____

**Pacific Power Customer Signature** **Date**

PACIFIC POWER
A DIVISION OF PACIFICORP

***A random sample of CARE participants will be required to provide proof of income.**