

## 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)

**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 gross 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	Yearly Income at or Below
1 or 2	\$2,133	\$25,600
3	\$2,508	\$30,100
4	\$3,025	\$36,300
5	\$3,542	\$42,500
6	\$4,058	\$48,700
7 and more	For households with more than 6 people, add \$517 for each additional individual to determine allowable income level.	For households with more than 6 people, add \$6,200 for each 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**

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

