MERCED IRRIGATION DISTRICT
WATER & POWER

# CARE Program Application

## 1. ACCOUNT INFORMATION

Name (as it appears on your MID bill)

Service Address

City | State | Zip Code

Mailing Address (if different from service address)

Phone Number | MID Account Number

Email Address

### How to Apply

1. Enter your account information
2. Enter household information
3. Attach Proof of total monthly income
   **MID will not accept bank statements as proof of income**
4. Email application to:

customerservice@mercedid.org

Or mail to:

**MID CARES**
**744 WEST 20TH ST.**
**MERCED, CA 95340**

** Incomplete applications will not be processed**

## 2. HOUSEHOLD INFORMATION & INCOME VERIFICATION

Including Applicant, Enter total number of persons living in the home (full-time basis)

Adults _____ + Minors (Under 18) _____ = _____ Total

Household income includes money from all house members (taxable or non-taxable), including but not limited to:

Wages $ _____
Interest income $ _____
Social Security $ _____
SSI, SSP, SSDI $ _____
Pensions $ _____
TANF (AFDC) $ _____
Child Support $ _____
Disability payments $ _____
Workers compensation $ _____
Unemployment benefits $ _____
Spousal support $ _____
Rental or royalty income $ _____
Legal settlements $ _____
Scholarships $ _____
Grants $ _____
Cash $ _____
Self-employed (IRS form Schedule C required) $ _____
Other income (explain)_____ $ _____

**Total Monthly Household Income (Gross): $_____**

If you need a copy of your Social Security Award Letter, please contact the local Social Security office by calling **1-800-772-1213.**

**Note:** If adults are listed on the application without Proof of income, please attach an explanation.

### CARE Program Income Limits

| Household Size Members in Household | Maximum Annual Gross income* |
|---|---|
| 1 to 2 | $34,840 |
| 3 | $43,920 |
| 4 | $53,000 |
| 5 | $62,080 |
| 6 | $71,160 |
| 7 | $80,240 |
| 8 | $89,320 |
| For each additional person add. | $9,080 per member |

## 3. DECLARATION AND SIGNATURE

*The information on this application will be used to determine and verify my eligibility for assistance. If eligible for the MID CARE Program discount, I permit the proper change to my rate schedule and consent to have my eligibility verified at any time. If verification establishes that I am ineligible, I will be removed from the program and the District may render corrective billings. I declare, under penalty of perjury, that the information on this application is true and correct.*

**X**_____
Signature (the person whose name appears on the MID bill) Date

MID USE ONLY

☐ Approved Date_____ Initials_____
☐ Denied ☐ Income too high ☐ Income not provided
☐ Incomplete Application ☐ Other

Once application is approved, the reduced "CARE" rate will remain in effect for two years unless an earlier verification establishes that I am ineligible. Therefore, it is the Customer's responsibility to re-apply for the reduced "CARE" Rate **PRIOR** to application expiration to avoid a rate increase.

**Please allow up to 60 days for the processing of the application. Processing will be delayed beyond 60 days if the application is incomplete or inaccurate. Utility bill accounts will begin receiving the discount after eligibility is verified and is not retroactive.**

REV. 06/08/2022