



SENIOR HEALTH & INCOME ENERGY LIFELINE DISCOUNT INFORMATION AND APPLICATION INSTRUCTIONS

The Senior Health & Income Energy Lifeline Discount (SHIELD) program helps seniors aged 60 and older who face high medical costs by providing a 30% discount on their power bill. **To qualify, medical and pharmaceutical expenses must be more than 10% of annual income.** Participation in the program requires renewal every three years. Customers are responsible for submitting a new application before their renewal date. Please review the eligibility requirements and include all necessary documents when applying.

Maximum Gross Income (Effective as of January 1, 2026)	
No. of Persons in Household	Combined Annual Household Income
1-2	\$68,103
3-4	\$103,523
Each Additional Person	\$17,710

To establish eligibility you must complete the enclosed application and return it, along with any supporting proof of income. The applicant must be the customer of record with IID. The discount will only be applied upon verification and approval.

Thank you for your interest in the SHIELD program. IID **encourages** you to also complete the **Energy Assistance for Special Equipment (EASE)** section below. As SHIELD applicants have high medical costs, you may also benefit from EASE, which provides a reduced electrical rate for single-family households with a full-time resident who relies on electric-powered medical equipment.

HOW TO APPLY

1. Complete and sign application (*also available for download at www.iid.com/shield*).
2. Provide proof of income verification for most current month (*everyone in residence and additional income may be required*) and proof of medical and pharmaceutical expenses that exceed 10% of annual income.
3. Most recent tax returns, including all schedules.
4. Provide identification and social security number for all adults.
5. Submit completed application, along with supporting documents to:
 - energyassistance@iid.com
 - fax (760)339-9744
 - mail to IID: PO Box 937, Imperial, CA 92251 (*pre-paid mailer enclosed*)
 - or in person at the following Customer Service Centers:

Brawley	Calexico	El Centro	La Quinta
135 S. Plaza St.	301 Imperial Ave.	1285 Broadway	81-600 Avenue 58

CHECKLIST

- Completed/signed application
- Proof of income (e.g., pay stubs, pension statements—no bank statements)
- Recent federal tax returns
- ID & SSN for adult members of household
- Proof of medical and pharmaceutical expenses (e.g., medical bills, insurance statements)

🕒 Office hours: Monday - Thursday, 8 a.m - 12 p.m. & 1 - 5 p.m. CLOSED ON FRIDAYS

Renewals:

- To avoid interruption of your discount, it is recommended that you apply 4-8 weeks prior to your renewal application expiration date.
- Your discount period is for 36 months from the day approved.

General Disclaimers:

- Your primary single-family residence must be in IID's service area.
- You must provide information requested within 10 working days or the application will be voided.
- Account must be in good standing to qualify.
- In order to qualify, tampering fees need to be paid in full, or have at minimum a 12 month good payment history of the tampering fees.
- **I agree to notify IID if my income changes.**

Change of Address:

- You are required to contact IID if you move and need SHIELD discount to continue at new address.

You Do Not Qualify for SHIELD if:

- You have multiple residential accounts or the residence is multi-family.
- You do not meet the income guidelines.
- You are enrolled in READY.
- There is an income tax discrepancy.
- History of unpaid debt/collections (power, water or miscellaneous).
- Other restrictions may apply.

For more information on SHIELD, please contact IID or visit our website at www.iid.com/shield.

1-760-339-9032 (SHIELD Representative) • 1-800-303-7756 (Customer Service) JAN 2026



SENIOR HEALTH & INCOME ENERGY LIFELINE DISCOUNT APPLICATION

TO BE COMPLETED BY CUSTOMER. (Entire application must be completed and signed. Please print clearly with black or blue ink.)

IID Contract Account Number (or name of mobile home park)	Telephone#
Customer Name (as shown on your IID bill)	Email

HOUSEHOLD INFORMATION AND INCOME VERIFICATION

Number of persons in my single-family household: Adults Children (under 18)
(include yourself, other adults and children)

Did anyone in your household file federal tax returns? Yes No

Total combined gross annual household income: (before taxes) \$ _____
(Will be required to show proof of income. Bank statement not acceptable form of proof.)

The definition of "gross annual household income" is all money and non-cash benefits, available for living expenses, from all sources, both taxable and non-taxable, before taxes and all deductions for all people who live in the home. This includes, but is not limited to, the following:

Please check (✓) ALL sources of your household income.

- | | | |
|---|--|---|
| <input type="checkbox"/> Wages, Salaries & Commission | <input type="checkbox"/> Disability/Workers Comp | <input type="checkbox"/> Self-Employment Income (Schedule C) |
| <input type="checkbox"/> Alimony/Spousal/Child Support/Foster | <input type="checkbox"/> Veterans Benefits | <input type="checkbox"/> Rental or Royalty Income (Schedule E) |
| <input type="checkbox"/> Unemployment Benefits | <input type="checkbox"/> Retirement/Pension | <input type="checkbox"/> Interest or Dividends from Savings, Stocks, Bonds or Retirement Accounts |
| <input type="checkbox"/> Cash Aid | <input type="checkbox"/> Social Security/SSI/SSP | <input type="checkbox"/> Other |

DECLARATION & SIGNATURE

I certify under penalty of perjury under the laws of the state of California that the information I have provided in this application is true and correct. The IID bill is in my name. I understand this application does not guarantee my participation in the program. **I am not claimed on another person's federal income tax return.** I agree to provide proof of my household income if requested by IID. I understand that IID may require me to submit a completed IRS 8821 form for income verification with the Internal Revenue Service. I, the account holder/ applicant, live on the premises. **I understand that while enrollment in the Average Bill Payment Plan is not required, it is highly encouraged.** **I agree to inform IID if I no longer qualify to receive the discount. I understand that when I receive any discount or benefit without meeting the qualifications for it, I may be required to pay back the discount I received. I understand that if my application is denied, I must wait six months before I can reapply. I understand that IID can share my information with other assistance program agencies.**

Customer Signature _____	Date _____
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I agree to receive calls at the above number and/or email, through an automatic-dialer, or a prerecorded message from, or on behalf of IID for rebates, savings, or other low-income qualified program information. I understand that consent to receiving these calls is not required to enroll in this program and that messages and data rates may apply.

FOR OFFICE USE ONLY			
<input type="checkbox"/> RENEW	<input type="checkbox"/> NEW	<input type="checkbox"/> MOVED	<input type="checkbox"/> WI <input type="checkbox"/> MAIL <input type="checkbox"/> EMAIL <input type="checkbox"/> FAX
Status _____	Initials _____	Date _____	
Comments _____			

ENERGY ASSISTANCE FOR SPECIAL EQUIPMENT INFORMATION**(OPTIONAL)**

Provide the following information for each piece of equipment (found on the manufacturer data plate). Please do not abbreviate the name of the equipment or its manufacturer.

Name of equipment	Full name of manufacturer	Volts	Amps	Hours/Days of use

Volts and AMPs section must be completed.

Please use an additional sheet if you need more space.

Although Imperial Irrigation District will make every effort to supply uninterrupted service, continuous service cannot be guaranteed. In the event of a power outage, patients requiring continuous service are responsible for providing their own backup power system. Program participation does not guarantee service on delinquent or past due accounts.

TO BE COMPLETED BY LICENSED MEDICAL DOCTOR OR DOCTOR OF OSTEOPATHY

Name of patient _____

The patient medically requires increased heating and/or cooling: Yes No

If yes, please explain medical need _____

REQUIRES USE OF A CRITICAL CARE DEVICE

(Check one) Yes No

The following critical care device(s) is(are) used in the patient's home:

Device

Medical Provider's Name	Business Telephone Number		
Business Address	City	State	Zip Code

I hereby certify that the above information reflects my medical judgement regarding this patient's need for medical equipment as outlined above.

Signature of M.D./D.O.

Date

Doctor's License Number

Exp. Date

FOR OFFICE USE ONLY

Installation _____ Qualifying Medical Equipment Usage _____ A/C _____ \$ _____

Effective Dates _____ Approved/Denied By _____