

**Child and Adult Care Food Program  
FAMILY INCOME-ELIGIBILITY APPLICATION**

**Mountainview Daycare Nutrition Program  
3131 Smokey Point DR, Suite 5A, Arlington, WA 98223  
360-653-7273**

**PART 1 – NAME OF CHILD CARE PROVIDER**

**PART 2 – CHILDREN’S INFORMATION—List all children in care**

Child’s Name	Birthdate	Is this a foster child?	Is this child enrolled in Head Start?	Is this child eligible for free or reduced-price meals at school?
		Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
		Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
		Yes ___ No ___	Yes ___ No ___	Yes ___ No ___
		Yes ___ No ___	Yes ___ No ___	Yes ___ No ___

**INSTRUCTIONS**

Please check the boxes that apply to help determine the other parts of this form to complete:

- A family member in our household receives benefits from Basic Food, TANF, or FDPIR. (Please complete Part 3 and 5.)
- One or more of the children in Part 2 is a foster child. (Please complete Part 5.) If any non-foster children, complete Part 3 or 4.
- My child(ren) qualify for Free/Reduced-Price meals based on household income. (Please complete Part 4 and 5.)

**PART 3 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to establish eligibility for all children in the household.**

Name	Circle One	Case Number or Identification Number
	Basic Food    TANF    FDPIR	

**PART 4 – TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 3**

List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month – Tell us how much and how often (or net income if self-employed) (if None, Write “0”)			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
<i>Jane Smith (example)</i>	<i>\$ 1000 / month</i>	<i>\$ 300 / month</i>	<i>\$ ___ / ___</i>	<i>\$ 100 / week</i>
1.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___
2.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___
3.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___
4.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___
5.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___
6.	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___	\$ ___ / ___

If Part 4 is completed, the adult signing the form must list the last four digits of their Social Security Number or the box must be checked that they do not have one (see Privacy Statement on the back of this page).

Adult’s Social Security Number (last four digits) XXX-XX-\_\_\_\_\_  I do not have a Social Security Number.

**PART 5 – SIGNATURE AND CERTIFICATION – REQUIRED**

I certify all of the above information is true and correct and all income is reported. I understand this information is being given for the receipt of federal funds; that institution officials may verify the information on the application; and that the deliberate misrepresentation of the information may subject me to prosecution under applicable state and federal laws.

Signature of Parent	Date Signed	
Print Name of Parent	Home Telephone	Work Telephone

\_\_\_\_\_ Initial here if you consent to allowing your provider to collect your form and provide it to the sponsor. Your provider will not review your form.

