

Metropolitan Development Council
 721 S Fawcett Suite 205 Tacoma WA 98402
 253-284-7865/800-843-9317

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

PART 1 – PROVIDER INFORMATION

Provider's Name			
Provider's Home Address		Home Telephone	
City	State	Zip	Work Telephone

PART 2 – HOUSEHOLD MEMBER RECEIVING BASIC FOOD, TANF, OR FDPIR—Only one household member receiving benefits must be listed in order to qualify for Tier I rates. Documentation with begin and end dates must be submitted to support the benefits.

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

PART 3 – FOSTER CHILDREN – List any foster children living in your home

PART 4 – PROVIDER'S OWN – List the names of children in your household who are of child care age

Child's Name	Age	Birthdate
1.		
2.		
3.		

PART 5 - TOTAL HOUSEHOLD INCOME FROM LAST MONTH—Not required if you have reported a case number in Part 2

List Names (First and Last) of everyone in your household, including foster children	Gross Income from Last Month (if None, Write "0") (or net income if self-employed)			
	Earnings from Work Before Deductions	Alimony, Child Support	Retirement, Pensions, Social Security	Job Two or Any Other Income
1.				
2.				
3.				
4.				
5.				
6.				
7.				

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 he does 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 6 – CERTIFICATION

I certify all of the above information is true and correct and all income is reported. I understand this income-eligibility application will be in effect for 12 months from the date it is signed, verified, and dated by the sponsor. 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 Provider	Date Signed
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PART 7 – IDENTIFYING INFORMATION AND CERTIFICATION OF DATA (You are not required to answer this.)

