

**Direct Deposit**

**Authorization Agreement for Automatic Deposit of Child Care Provider Payments**

This form authorizes the Reimbursement agent to deposit child care provider payments directly into the bank account listed below and, if necessary, reverse any incorrect credit entries made in error related to the provider payments. I agree to resubmit this form immediately if this bank or bank account changes or if I decide to stop direct deposit.

**Please Check One of the Options Below:**

**New Application**

**Change Direct Deposit Information**

**Cancel Direct Deposit**

**Waive Direct Deposit**

**NO CHANGES - New Contract Year (Please omit completing this form if there are no changes at this time).**

***Child Care Provider Information:***

Name of Provider or Business: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Telephone Number \_\_\_\_\_

Provider Identification Number: \_\_\_\_\_  
Tax ID Number –or- SSN

***Information on Financial Institution:***

Name of Bank: \_\_\_\_\_

Address: \_\_\_\_\_

Bank's City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number of Bank: \_\_\_\_\_

Type of Account:                      Checking Account       Savings Account

Bank Transit / Routing Number: \_\_\_\_\_  
(Ask bank for the transit/routing number for direct deposit)

***Bank Customer Information:***

Bank Account Number: \_\_\_\_\_

Name of Bank Account Holder: \_\_\_\_\_

**PLEASE ATTACH VOIDED CHECK OR DEPOSIT SLIP (SAVINGS ACCOUNT ONLY) TO THIS APPLICATION**

▶ \_\_\_\_\_  
**Signature of Provider**

\_\_\_\_\_  
**Date**