

DIRECT DEPOSIT AUTHORIZATION

Before completing this form, please read the back to make sure you understand the terms and conditions of this agreement. Fill in the boxes below, sign and mail the completed form to the: Childs Payment Unit – 944C, PO Box 6123, Phoenix, AZ 85005-6123.

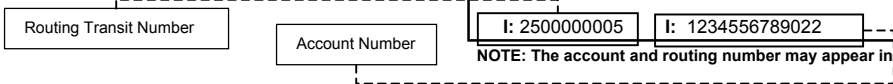
PROVIDER/FACILITY NAME		
PROVIDER ID	PROVIDER SUFFIX	FACILITY ID
EMAIL ADDRESS TO RECEIVE WARRANT ADVICE <i>(You must have an email address to participate in the Direct Deposit Program)</i>		
ACTION <input type="checkbox"/> New <input type="checkbox"/> Change <input type="checkbox"/> Cancel	EFFECTIVE DATE / /	DAYTIME CONTACT PHONE NUMBER () -
NAME OF FINANCIAL INSTITUTION		
ACCOUNT NUMBER <i>(Include hyphens but omit spaces and special symbols)</i>	TYPE OF ACCOUNT <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
ROUTING TRANSIT NUMBER	<i>(All 9 boxes must be filled. The first two numbers must be 01 through 12 or 21 through 32)</i>	OWNERSHIP OF ACCOUNT <input type="checkbox"/> Self <input type="checkbox"/> Joint <input type="checkbox"/> Other
<p>I certify that I have read and understand the back of this form. By signing this agreement, I authorize DES/DCYF to initiate credit entries to the account indicated above for the purpose of payments to my account(s). I also authorize DES/DCYF to initiate, if necessary, debit entries and adjustment for any credit entries made in error. I will notify the State of Arizona of any known changes or closure of my bank account. When the State of Arizona is notified by my financial institution of changes affecting this direct deposit. The State of Arizona is authorized to make the applicable charges. This authorization is to remain in effect until a new authorization is received.</p>		
Signature _____		Date / / _____
Signature _____		Date / / _____

HOW TO COMPLETE THIS FORM

1. Read the back of the form completely.
2. Fill in all boxes above; sign and date the form.
3. Attach a voided check or deposit slip to the form.
4. If the account is not in your name alone, have the other account holder sign also.
5. Mail the form to the address listed above.

- Tip** Call your financial institution to make sure they will accept direct deposits.
- Tip** Verify your account number and routing transit number with your financial institution.
- Tip** Use a check, not a deposit slip to verify the routing number.

JOHN PUBLIC	1234
123 Main Street	_____ 20 _____
Your Town, FL 12345	\$ _____
	_____ DOLLARS
Your Town Bank	
Your Town, SL 12345	
For _____	
I: 2500000005	I: 1234556789022



NOTE: The account and routing number may appear in different place on your check.

TERMS AND CONDITIONS FOR PARTICIPATING IN THE DES DIRECT DEPOSIT PLAN

You have the option of having your compensation deposited directly into your account at your financial institution rather than receiving the payment by US mail. The following are the terms and conditions for participating in the DES/DCYF Direct Deposit Program. The DES/DCYF Direct Deposit program is optional.

1. Your financial institution must be a member of an Automated Clearing House in order for you to participate in the DES/DCYF Direct Deposit Program.
2. You must complete this authorization form to enroll in the DES/DCYF Direct Deposit Program. A signed and dated form is required for processing, as well as a voided check. If you have a joint account, the form must be signed by both parties. Once your form is received by DES/DCYF; there may be up to a four (4) week administrative processing period before the enrollment will become effective. You will receive a check by US mail for any compensation or fees paid during this period. DES/DCYF compensation will be paid in accordance with the DES Policies and Procedures.
3. The standard turn-around time for deposit into your account is 48 hours from the time DES/DCYF transmits the entries. You should verify that the deposit has been made to your account before withdrawing funds.
4. If an electronic transfer is returned to DES/DCYF or for any reason cannot be made to your account, DES/DCYF will issue and mail a check to you. Pending resolution of the electronic transfer problem, you will continue to receive compensation checks in the US mail. Reinstatement in the DES/DCYF Direct Deposit Program will be determined on a case-by-case basis, and you will be notified of any action taken by DES/DCYF.
5. It is your responsibility to notify DES/DCYF Payment Processing Unit immediately of any changes in your account such as account closure or change in account number. Complete this form indicating the action is a CHANGE, and specify the new account information. There may be up to a four (4) week administrative processing period before the changes become effective. If there is an interruption in the DES/DCYF direct deposit service, you will receive checks for any compensation during that time by US mail.
6. You may cancel your participation in the DES/DCYF Direct Deposit Program at any time by completing this form indicating the action is a CANCEL. The cancellation will take effect as of the date you indicate or as soon as the form is received and processed by DES/DCYF, whichever is later.
7. This agreement may also be canceled by your financial institution or DES/DCYF. DES/DCYF reserves the right to automatically cancel your participation in the DES/DCYF Direct Deposit Program.

If you have any questions regarding this form or the Direct Deposit Program, please call the DES/DCYF Payment Processing Unit @ 602-542-5610, Monday through Friday, 8 am to 5 pm, Mountain Standard Time.

Equal Opportunity Employer/Program • Under Titles VI and VII of the Civil Rights Act of 1964 (Title VI & VII), and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program or activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact your local office; TTY/TDD Services: 7-1-1. • Free language assistance for DES services is available upon request. • Disponible en español en línea o en la oficina local.