Office of Financial Management

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INSTRUCTIONS FOR COMPLETING THE AGENCY PROVIDER DIRECT DEPOSIT AUTHORIZATION FORM FOR WASHINGTON STATE DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

The Direct Deposit Authorization form should be used to perform one of the following:

- Set-Up Direct Deposit Payment
- Modify existing Direct Deposit arrangements
- Cancel Direct Deposit and re-instate payment through U.S. mail

Please Note: ***If writing instead of typing, please PRINT clearly in Dark Blue or Black Ink. Forms will not be accepted if they have whiteout, have been crossed off, or have been written over.***

PART A Identification Details:

- You MUST provide your Statewide Vendor Number unless this form accompanies a new registration.
- If you do not know your Statewide Vendor Number use the link provided - *http://des.wa.gov/vendorlookup*
- You MUST provide your legal name as it appears with the IRS.
- You MUST provide your Social Security Number (SSN) OR Employer Identification Number (EIN). Do **not** provide both.

PART B Payment Option:

- Check the box indicating your preferred method of payment.

PART C Direct Deposit Information and Signature:

- If you checked Direct Deposit in Part B, fill out **all** fields in Part C.
- Please note that if the Account type is left blank we will default to checking account.
- Please note that if Payment type is left blank, we will default to corporate/business payment.
- Please sign with a pen (a "**wet signature**"). Stamped, inserted or electronic signatures will **not** be accepted.

Please Note*: Forms must be signed in order for any changes to take effect.*

For questions, please contact the Department of Children, Youth and Families at 360-664-6161

Or by email at ProviderFileUnit@dshs.wa.gov

Submitting the Department of Children, Youth and Families Payee EFT Form:

- Please PRINT and SIGN the completed form
- SCAN to PDF format and Email to: ProviderFileUnit@dshs.wa.gov **OR**
- FAX to: (360) 902-8268 **OR**
- MAIL to: DCYF, PO Box 45812, Olympia, WA 98504

PLEASE
DO NOT
STAPLE

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AGENCY PROVIDER DIRECT DEPOSIT AUTHORIZATION FORM FOR WASHINGTON DEPARTMENT OF CHILDREN, YOUTH AND FAMILIES

Important Note: For changes to existing banking arrangements you will be contacted via the Email or Telephone Number or Physical Mailing Address we have on file to verify the change.
Changes will not take effect until they are successfully verified with the contact person on file.

PART A: Enter Identification Details - ALL FIELDS REQUIRED

Statewide Vendor Number: | S | W | V | | | | | | | | - | | |

Legal Name: _____

Taxpayer Identification Number: (EIN or SSN) | | | | | | | | | |

SSPS # (if known)

MERIT PROVIDER # (if known)

MERIT STARS # (if known)

PART B: Select Payment Option

☐ Direct Deposit to bank (recommended)

☐ Check in US mail (terminates any previous banking information on file)

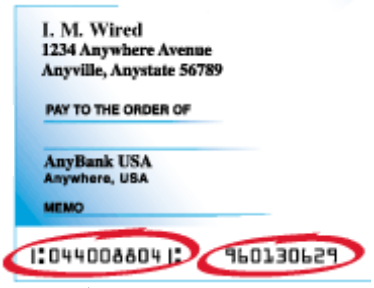
PART C: For Direct Deposit, complete all fields below then print and sign

In addition to providing your banking information on this form, you may also attach a voided check.

_____ (_____)_____-_____
Financial Institution Name – must be a US institution — Financial Institution Telephone Number

Routing Number – see example at right

_____
Account Number – see example at right



Routing number (nine digits) — Account Number (can vary in length)

Account Type ☐ Checking ☐ Savings

Payment Type ☐ PPD (Personal) ☐ CCD (Corporate/Business)

Authorization for Direct Deposit

I hereby authorize and request the Office of Financial Management (OFM) and the Office of the State Treasurer (OST) to initiate credit entries for payee payments to the account indicated above, and the financial institution named above is authorized to credit such account. I agree to abide by the National Automated Clearing House Association (NACHA) rules with regard to these entries. Pursuant to the NACHA rules, OFM and OST may initiate a reversing entry to recall a duplicate or erroneous entry that they previously initiated. I understand that, if a reversal action is required, OFM will notify this office of the error and the reason for the reversal. This authority will continue until such time OFM and OST have had a reasonable opportunity to act upon written request to terminate or change the direct deposit service initiated herein.

_____ _____
Authorized Representative (Please Print) — Title

_____ _____
SIGNATURE of Authorized Representative
(No stamped or electronic signatures please) — Date