To: Daycare Voucher Check Participants

From: Ivory Daniels, Family Support Unit Administrator

RE: Direct Deposit Authorization Form

Direct Deposit is a feature within the Automated Child Care System that is available to all license Daycare Voucher participants as an alternative method to receive daycare payments that will allow deposit directly to you checking/saving account. Requests for Direct Deposit must be submitted to DCC/ECE and must be signed by the owner. Owners may delegate this to an authorized representative. Authorized representatives must be identified in writing and be on file with DCC/ECE. You will receive a payment stub through the mail a few days after your payment is deposited to your account.

If you are interested in this option, please complete the attached form, attach a **VOIDED CHECK** and return to our office at the address below. If you have any questions with completing this form, please contact Ms. Delois Calhoun at (501) 683-0032 or 1-800-322-8176.

Arkansas Department of Human Service
Division of Child Care and Early Childhood Education
ATTN: Delois Calhoun
P O Box 1437 slot s/145
Little Rock AR  72203-1437

Encl: DD Authorization Form and Sample Form
    W-9 Request for Taxpayer Identification Number and Certificate
Arkansas Direct Deposit System
General Expense Direct Deposit Authorization Form

AGENCY CODE 710  AGENCY TITLE: FAMILY SUPPORT UNIT  DATE: ___/___/___

CONTACT PERSON: Delois Calhoun – DHS – Family Support Unit
P.O. Box 1437 – Slot – S145
Little Rock AR 72203

Telephone: (501) 683-0032 / 1-800-322-8176

CHECK WHERE APPLICABLE

_______ NEW ENROLLMENT

_______ CHANGE OF PRESENT FINANCIAL INSTITUTION AND/OR ACCOUNT
COMPLETE ENTIRE FORM AND SIGN

_______ CANCEL PARTICIPATION (PLEASE SIGN FORM)

I hereby authorize the Arkansas Direct Deposit System (ADDS) to deposit to my account indicated below the net amount I am due as if a warrant had been delivered to me for that amount. I also authorize the financial institution indicated below to credit the net amount to the account. Should an incorrect entry be made, (ADDS) is authorized to initiate debit entries to my account necessary to correct the incorrect credit entries.

Financial Institution Name (Bank)/contact number: ___________________________ / (__ ) ___________

Location of Bank (CITY): ___________________ State: ______ Zip: __________________________

Select One Method:  Checking Account __________  Saving Account ______________________

This authority is to remain in full effect until (ADDS) has received written notification from me of its termination. I understand that by having my payment deposited in this manner, a direct deposit advice notification will be available and that there will be no charge.

Social Security _____ - _____ - ______  Federal ID: _______________________________

Name (Facility) __________________________ Facility Number____________________________

Address: __________________________________________________________________________

City: _______________________ State: ____________________ Zip: ___________________________

Date: ___/___/______  Owner/ Authorized Representative Signature: __________________________

ATTACH VOIDED CHECK

AGENCY USE ONLY

BANK ROUTING NUMBER  ACCOUNT NUMBER  ACCOUNT TYPE
________________________  __________________  __________________