Office of Financial Management
Better information. Better decisions. Better government. Better Washington.

Provider Direct Deposit Authorization Form

Instructions For Completing the Provider Direct Deposit Authorization Form

The Direct Deposit Authorization Form should be used to perform the following:
Set-Up Direct Deposit Payment.
To change your bank account.
Cancel direct deposit and reinstate payments by check.

Note:
If writing instead of typing, please PRINT clearly in blue or black ink only. 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 VENDOR LOOKUP page.
You must provide your legal name as filed with the IRS.
You must provide your DBA if you have one.
You MUST provide your Social Security Number (SSN) OR Employer Identification Number (EIN).

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.
Your bank's name is required.
If the Account type is left blank, we will default to Checking account.
If the Payment type is left blank, we will default to Corporate/Business payment.

Important: After confirmation, it will take three– to– five business days for your direct deposit to activate.

Signature Block:
Please sign with a pen (a "wet signature").
Electronic, inserted or stamped signatures will not be accepted.
This form is not considered valid unless it is signed.

Submitting the Provider Direct Deposit Authorization Form:
Please PRINT and SIGN the completed form
SCAN to PDF format and EMAIL to: ProviderFileUnit@dshs.wa.gov
MAIL to: DCYF, PO Box 45812, Olympia, WA 98504

For questions about the form, please contact the Payee Registration Unit at (360) 407-8180 ext. 5. For any other questions, please contact the agency you are expecting payment from.

Office of Financial Management
Better information. Better decisions. Better government. Better Washington.

PLEASE DO NOT STAPLE

Provider Direct Deposit Authorization Form

Important: For changes to existing banking arrangements, you will be contacted via email, telephone number, or physical mailing address 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 (Except SWV on new registration)

New registration? ☐ Yes ☐ No (if no, please enter your SWV number)

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

Legal Name**:** _____

DOING BUSINESS AS (DBA): _____

Taxpayer Identification Number: | | | | | | | | | |

(SSN or EIN)

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

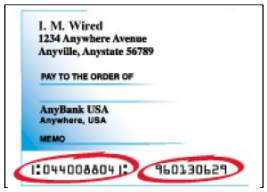
In addition to providing your banking information on this form, you may also attach a voided check.

Financial Institution Name – must be a US institution: _____

Financial Institution Telephone Number: _____

Routing number – see example at right: _____

Account Number – see example at right: _____



Account Type: ☐ Checking ☐ Savings

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

Authorization for Direct Deposit

I hereby authorized 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 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 Date: This form is valid for 90 days