

DCC – 93 05/23	COMMONWEALTH OF KENTUCKY Cabinet for Health and Family Services Department for Community Based Services Division of Child Care	Date Received
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Authorization for Electronic Deposit

Request Type must be checked:

- ☐ Initial Request
 Change to existing financial institution or account
☐ Cancel electronic deposit, for payment to be made by paper check

Change to payment option is limited to three (3) times in a calendar year.

PROVIDER INFORMATION (MUST be printed or typed)

Owner Name	Director Name
Business Name	
Business Address	City, State, Zip
Business Phone	
FEIN/SSN	CLR #

FINANCIAL INSTITUTION INFORMATION (MUST be printed or typed)

Financial Institution	
Address	City, State, Zip
Account Type: ☐ Checking ☐ Savings	
Routing/ABA Number	Account Number

Request must include:

- 1) Voided check (no temporary checks) **OR**,
- 2) Bank Letter, that includes a-d, **OR**,
 - a. Bank letterhead including the address
 - b. Accounting and routing numbers
 - c. Name of business attached to the account
 - d. Title and phone number of person signing letter
- 3) Direct Deposit form generated online from the bank account (must include name, account, and routing numbers, **AND**
- 4) Photo IDs for both parties signing below.

I, the undersigned, authorize the Commonwealth of Kentucky to initiate accounting transactions to deposit payments directly to the account indicated above and to correct any error which may occur from the transactions. I also authorize the Financial Institution to post these transactions to that account. This authorization is to remain in force until the Commonwealth of Kentucky receives written notice or cancellation from me.

Director's Signature (Required)

Date

Owner's Signature (Required)

Date

Submit to: CCAPProviderPayments@ky.gov or Division of Child Care, 275 East Main Street, 3C-F, Frankfort, KY 40621

