



# Authorization Agreement for Reimbursement Options of 4C CNP FAMILY CHILD CARE

**All reimbursement information must be submitted to 4C in writing.**

I hereby authorize 4C for Children, hereinafter called "4C," to initiate electronic entries to my (select one account below):

### Bank Account:

\_\_\_\_\_ Checking Account<sup>1</sup>

You must attach *one* of the following:

- a voided check with account and routing numbers and magnetic media numbers on the bottom of the check.
- an ACH statement from your bank with account and routing numbers.

\_\_\_\_\_ Savings Account<sup>1</sup>

You must attach the following to this form:

- an ACH statement from your bank with account and routing numbers.

### Prepaid Card:

\_\_\_\_\_ Prepaid Reloadable Card<sup>2</sup> issued by US Bank, "FocusCard"

\_\_\_\_\_ Other Prepaid Card<sup>2</sup> You must attach the following:

- Prepaid card account information form with account and routing numbers.

<sup>1</sup> **Please note:** Deposit slips are not acceptable. No hand written bank information will be accepted.

<sup>2</sup> **Please note:** By completing this form, you agree that 4C is not responsible for any issues related to the prepaid card, including delays in the availability of funds.

### Discontinue Direct Deposit:

\_\_\_\_\_ Discontinue my current direct deposit and switch reimbursement to the method indicated above.

*(If you do not select a new method above, your reimbursements will be switched to the Prepaid Reloadable Card method.)*

Provider's Name: \_\_\_\_\_ Provider's signature: \_\_\_\_\_

Street Address: \_\_\_\_\_ City/ State/ZIP: \_\_\_\_\_

E-mail address: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Bank/Financial Institution Name: \_\_\_\_\_ Bank's City/State/ZIP: \_\_\_\_\_

*This authority is to remain in full force and effect until 4C has received written notification from me of its termination, in such time and in such manner as to afford 4C and the Financial Institution a reasonable opportunity (typically one month) to act on it.*

#### 4C OFFICE USE ONLY:

Submitted to Finance Dept. on \_\_\_\_\_ 4C Specialist \_\_\_\_\_

Finance ID Number \_\_\_\_\_ New Provider \_\_\_\_\_ Returning Provider \_\_\_\_\_