EARLY LEARNING COALITION OF THE BIG BEND REGION, INC
PROVIDER AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER FORM

Provider Name: _____

Please Check One: ___ **New Application** __ **Change** __ **Termination** ___ **Re-Authorization**

I hereby authorize the Early Learning Coalition of The Big Bend Region, Inc (the Coalition) to deposit my SR and/or VPK payments directly into my **BUSINESS** checking or savings account as indicated below and agree that such credit to these accounts constitutes payment and receipt by me. The Coalition reserves the right to recall funds sent in error and to interrupt or discontinue Electronic Payment and issue paper checks at any time for any reason.

I am aware that it can take up to one payment cycle from the date the Coalition Finance Department receives this form for it to become effective due to pre-note verification. Funds transferred by electronic transmission can take two to three banking days after the scheduled payment date to post to your account. **I am always responsible for verifying that the funds have been credited into the proper account and are available prior to writing checks or otherwise withdrawing funds from these accounts.** The Coalition is not responsible for late deposits and will not be responsible for overdrafts on any of the accounts listed below.

I am aware that I must give the Coalition Finance Department written notification to change or terminate my Electronic Payment and that it can take up to thirty (30) days for the Coalition to implement my request. In addition, I am aware that my Electronic Payment will be stopped upon termination of my status as a Network Provider.

1. Complete if this is a re-authorization and none of the program or banking information has changed.

☐ **By checking this box and signing below, I am indicating that I have verified the EFT information previously provided to the Coalition and that I acknowledge that this information has not changed.**

Provider Signature: _____
(Signature) (Date) (Phone Number)

Account Holder Signature (if different): _____
(Signature) (Date) (Phone Number)

2. Complete if you are a new provider or changes occurred with your banking or program information.

Social Security Number or Federal ID Number: _____

Account Information:

Bank_____
(Bank Name) (Bank Address & Phone Number)

☐ **BUSINESS Checking Account** (Please attach a voided CHECK for verification purposes)

☐ **BUSINESS Savings Account** (Please check with your bank to verify acceptance & routing number)

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Routing Number ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Provider Signature: _____
(Signature) (Date) (Phone Number)

Account Holder Signature (if different): _____
(Signature) (Date) (Phone Number)

FOR COALITION USE ONLY

EFS VENDOR # _____	VPK PREPAY VENDOR: YES NO