outh Dakota Department of Social Services

CHILD CARE PAYMENT AUTHORIZATION FORM
DIRECT DEPOSIT

(effective as soon as form is processed by CCS office)

Provider Information	
Name:	Provider Number:
Business Name:	
Mailing Address:	
City:	State/Zip:
Daytime Telephone Number:	
Tax ID or Social Security Number:	

Complete the following information:
Name of Your Financial Institution:
Financial Institution Address:
Financial Institution City: State/Zip:
Financial Institution Telephone Number (if known):
Type of Account: ☐ Checking ☐ Savings

I authorize the Department of Social Services to credit my provider payments to the account listed below, and if necessary, reverse any incorrect credit entries made in error. I acknowledge that a new enrollment form must be completed if I choose to change financial institutions or account numbers.

Your Signature _____ **Date** _____

***Remember to attach a voided check/copy of check to this form or a letter from your financial institution including your routing and account numbers. Do not attach a deposit slip; the routing number is not always correct.**

Mail this completed form to:

Child Care Services
Department of Social Services
910 E. Sioux Avenue
Pierre, SD 57501