

STATE OF ALASKA

ELECTRONIC PAYMENT AGREEMENT

Mail completed form to:
 OFFICE OF CHILDREN'S SERVICES
 DEPT OF HEALTH & SOCIAL SERVICES
 PO BOX 110630 / JUNEAU AK 99811-0630
 or FAX to: (907) 465-3190

* Indicates required field.

FOR SUBSIDIZED ADOPTION / GUARDIANSHIP AND FOSTER PARENTS

A voided check or other banking documentation **MUST** be attached with this agreement to verify your banking information. Failure to provide documentation will result in your form not being processed.

PARENT / PROVIDER INFORMATION

STATE OF ALASKA VENDOR NUMBER		PROVIDER NUMBER			
CHECK APPROPRIATE BOX *		SUBSIDIZED ADOPTION/GUARDIANSHIP		FOSTER PARENT	
PARENT/PROVIDER LEGAL NAME *			SOCIAL SECURITY NUMBER *		
PARENT/PROVIDER LEGAL NAME (if included, form must be signed below)			SOCIAL SECURITY NUMBER		
IS MAILING ADDRESS NEW? * YES / NO	MAILING ADDRESS *	CITY	STATE	ZIP CODE + 4	
CONTACT NAME	DAYTIME PHONE *	CONTACT EMAIL ADDRESS	EMAIL ADDRESS <i>for copies of remit advice</i>		

BANKING INFORMATION

The State of Alaska sends a pre-note zero dollar test transaction to verify the accuracy of the banking information below. Payments will not be sent electronically until the pre-note process is complete, generally five business days. The State of Alaska will contact you if the pre-note fails.

ARE YOU ADDING, CHANGING (<i>must provide OLD acct info</i>) OR CANCELLING THIS AGREEMENT? *					
NEW ACCOUNT INFORMATION *			OLD ACCOUNT INFORMATION or		
FINANCIAL INSTITUTION NAME		ACCOUNT TYPE Checking Savings	ACCOUNT INFORMATION that needs to be canceled <i>For verification purposes, you must provide your old accounting information if requesting a change, or the account information you want to cancel.</i>		
ACCOUNT NAME (Business / Legal Name on Account)			FINANCIAL INSTITUTION NAME		
ABA/ROUTING TRANSIT NUMBER	FULL ACCOUNT NUMBER	ABA/ROUTING TRANSIT NUM	FULL ACCOUNT NUMBER		
<p>NOTE: Payments are deposited separately with one addendum (remittance) record for each payment.</p> <p>NACHA Operating Rules requires your banking institution to provide you with addenda (remittance) information that the State includes on each payment. Any banking charge to receive this information is the responsibility of the account holder.</p>					

AGREEMENT AND AUTHORIZATION

I hereby authorize the State of Alaska to satisfy payment obligations due me by making deposits to the account indicated above. I understand that receipt of the electronic fund transfer(s) will fulfill the State's payment obligation and the State will be credited for the full amount on the date the fund transfer is completed. I understand the State will make a reasonable effort to notify me within 24 hours if a reversing entry is made against this account. This authority is to remain in full force through the duration of this agreement. I understand that thirty (30) days written notice is required if I change financial institutions, account numbers or type of account.

In addition, as required by the Federal Office of Foreign Asset Control in support of U.S.C. Title 50, War and National Defense, I attest that the full amount of my direct deposit is not being forwarded to a bank in another country and that if at any point I establish a standing order with my receiving bank to forward the full direct deposit to a bank in another country, I will inform the State of Alaska immediately.

I certify all information regarding this authorization is true and correct. Any intent to falsify information is punishable under AS 11.56.210 as a class A misdemeanor.

If the State discovers that the full amount of a direct deposit has been forwarded to another country or if information on the form has been falsified, this agreement shall be terminated. All correspondence with the State concerning this agreement or any changes to account information should be sent to the address at the top of this form. All terms remain in effect until this agreement is terminated by either party.

PRINTED NAME *	SIGNATURE *	DATE *
PRINTED NAME	SIGNATURE	DATE