EARLY LEARNING COALITION OF MIAMI-DADE AND MONROE COUNTIES
PROVIDER PAYMENT APPLICATION

PLEASE DOWNLOAD

An authorized representative must bring completed form to office (Please bring ID)

All providers must approve the following information in order to receive reimbursement from the Coalition.

Type of Entry: NEW CHANGE

Name of Facility: _____

Address: _____

City, State, Zip Code: _____

Tax ID OR SSN: _____ **DCF LIC Number:** _____

Phone Number: _____ **Email:** _____

Director/Owner: _____

PLEASE COMPLETE THE FOLLOWING SECTION:

I (we), hereinafter the PROVIDER, hereby authorize the Early Learning Coalition of Miami-Dade/Monroe Counties, hereinafter the COMPANY, to credit entries to our account indicated below and the financial institution named below, hereinafter called FINANCIAL INSTITUTION, to credit the same to such account:

Bank Name	Account Number	Routing Number

Please select the Type of Account:

Checkings-Personal Account **Checkings-Business Account**

Savings-Personal Account **Savings-Business Account**

This authority is to remain in full force and effect until COMPANY has received written notification from PROVIDER of its termination and such time and manner as to afford the COMPANY and FINANCIAL INSTITUTION a reasonable opportunity to act on it. I certify that the information in this form is correct.

X _____ _____

Signature of the Authorized Representative/Owner ***Date***

PLEASE ATTACH COPY OF VOIDED CHECK

Contract Use Only:

Approved by: _____

Contract Specialist Signature

*Please check off below list before signing

__ Verified Contract / Authorized Provider Representative submitted ACH form

__ Form is completely filled out

__ Voided check is attached

__ Authorized Contract specialist emailed form to accounting@elcmdm.org

Finance Use Only:

Approved by: _____ **Date:** _____