



## PROVIDER PAYMENT OPTION FORM

Provider Name: \_\_\_\_\_

Provider Social Security: \_\_\_\_\_

Provider Employer ID: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

The Children's Cabinet offers three payment options. Please check the one you wish to use:

A.  Please mail my check to the address listed above.

B.  Please add me to the Check Pick Up List (Rock Office only for Check Pick Ups).

I authorize the following person/persons to be added to the check pickup list.

Name \_\_\_\_\_ Phone \_\_\_\_\_  ID Attached

Name \_\_\_\_\_ Phone \_\_\_\_\_  ID Attached

Please remove the following person/persons from the check pick up list.

Name \_\_\_\_\_ Date: \_\_\_\_\_

C.  I choose to have my check Direct Deposited  Checking  Savings

**Please Attach Voided Check or Direct Deposit Verification form from your Bank here.  
Do not Attach deposit slips as the numbers are different from your account number.**

**Direct Deposit authorization will remain in effect unless I provide written notification  
terminating my Direct Deposit Payment.**

*Printed Name*

*Authorized Signature*

*Date*

**Please send this form along with a copy of your Driver's License or State ID to:  
The Children's Cabinet· Attn: Finance· 1090 S. Rock Blvd· Reno, NV 89502**