

Privacy Act Statement (PAS)

Authorities – This information is requested pursuant to the National and Community Service Act of 1990 as amended (42 USC 12501 *et seq.*), the Domestic Volunteer Service Act of 1973 as amended (42 USC 4950 *et seq.*), and E.O. 9397 as amended. **Purposes** – It is requested to manage, administer, and evaluate the childcare benefits program offered to eligible AmeriCorps Service Members. **Routine Uses** – Routine uses of this information may include disclosure to (1) contractors to assist with administering the childcare benefit, (2) individuals and organizations providing childcare, and (3) federal, state, or local agencies pursuant to lawfully authorized requests. A complete list of uses can be found in the system of records notice associated with this collection of information, [CNCS-06-CPO-ACB-AmeriCorps Child Care Benefit System \(ACB\)](#). **Effects of Nondisclosure** – This request is voluntary, but not providing the information will likely affect your ability to receive childcare benefits.

SECTION A

Instructions are on Page 2

1. TYPE OF ACTION: a. <input type="checkbox"/> NEW b. <input type="checkbox"/> CHANGE c. <input type="checkbox"/> CANCEL			
2. YOUR NAME (if an individual) or COMPANY NAME (if a business): _____		6. EMAIL ADDRESS: _____	
3. PHONE NUMBER (Only enter 10 digits): _____		7. ADDRESS: _____	
4. FAX NUMBER (If Applicable): _____	City	State	Zip Code
5. INTERNATIONAL ACH TRANSACTION (NACHA Requirement): <input type="checkbox"/> The entire amount of my direct deposit payment IS ultimately deposited to a financial institution outside the U.S. <input type="checkbox"/> The entire amount of my direct deposit payment IS NOT ultimately deposited to a financial institution outside the U.S.			

SECTION B – Financial Institution Information

1. ACCOUNT TYPE (1): a. <input type="checkbox"/> SAVINGS b. <input type="checkbox"/> CHECKING ACCT TYPE (2): a. <input type="checkbox"/> PERSONAL b. <input type="checkbox"/> COMMERCIAL		5. FINANCIAL INSTITUTION TELEPHONE NUMBER: _____	
2. ABA Routing or Transit Number: _____		6. YOUR NAME (if an individual) or COMPANY NAME (if a business): _____	
3. Depositor Account Number: _____		7. ADDRESS: _____	
4. FINANCIAL INSTITUTION NAME: _____	City	State	Zip Code

SECTION C –

Important! Please read and sign before submitting.

CANCELLATION / CHANGE OF ACCOUNT

The agreement represented by this authorization remains in effect until canceled in writing by the payee or until the program is suspended or terminated by **GAP Solutions, Inc.** Payments to you will be deposited into the account designated below until **GAP Solutions, Inc.** is notified in writing that you wish to cancel this authorization or designate a different Financial Institution or account. Six (6) to ten (10) banking days are needed to execute your instructions. To make any changes, you must submit a new Authorization Form with the updated information. If any action or inaction taken by the payee results in non-acceptance of an EFT deposit by the designated Financial Institution, payee acknowledges that **GAP Solutions, Inc.** has no responsibility to issue another payment until the funds for the non-accepted deposit are returned to **GAP Solutions, Inc.** by the Financial Institution. If non-acceptance by the Financial Institution is the result of action or inaction taken by the payee, late fees and penalties including consequential damages caused by this non-acceptance do not apply. **Please DO NOT CLOSE YOUR ACCOUNT UNTIL ONE WEEK AFTER NOTIFYING GAP Solutions, Inc.**

RECOVERY OF FUNDS DEPOSITED IN ERROR

In the event that an erroneous EFT payment occurs, creating an over-payment, **GAP Solutions, Inc.** reserves the right to debit your account for an amount not to exceed the amount of the erroneous EFT payment. In the event that a debit adjustment cannot be implemented, **GAP Solutions, Inc.** may utilize any other lawful means to recover payments to which the account holder is not entitled, including deducting the amount owed from future payments until the total over-payment is recovered. By signing this form, account holder(s) acknowledge their acceptance of these terms and conditions.

I/We certify that I/we have read and understand the information contained in Section B, above. I/We authorize **GAP Solutions, Inc.** to deposit payments and make

over-payment adjusting debits to my/our account as designated below. I certify that I am authorized to enter into this agreement on behalf of the account holder.

1	Signature of Account Holder	Print Name	Title (Company Account)	Date
2	Signature of Joint Account Holder	Print Name	Title (Company Account)	Date

For EFT/Direct Deposit service on child care provider subsidy payments:

- 1) Complete sections A, B and C.
- 2) Send the original completed form to:

GAP Solutions, Inc.
205 Van Buren Street
Suite 205
Herndon, VA 20170
Fax Number: 800-521-5415

Uploading the documents via our online application and faxing are the most secure methods of sending documents to our office. If you do decide to email any of your documents, please ensure you encrypt the documents, then send the documents in one email and the password in a separate email. That will help protect your information from any unintended recipients.

Specific Instructions

Section A

- 1) **Type of Action:**
New – Mark this box for new enrollment, or re-enrolling after a cancellation.
Change – Mark this box if adding to or changing any existing information. NOTE - If changing only the telephone number, email address, or mailing address, Section C may be left blank. However, if changing any banking information, please also fill out Section C.
Cancel – Mark this box to withdraw authorization for EFT/direct deposit payments. Payments will be paid by paper check instead, and mailed to the address provided on this form.
- 2) **Your Name:** Please provide your name (if an individual) or **Company Name** (if a business).
- 3) **Telephone Number:** Please provide a telephone number where you may be reached during business hours in case there are any challenges setting up this service or delivering a future payment to you. When you are entering this or any other phone or fax number, please do not enter dashes, commas, parenthesis, or other characters. Only enter the 10 digit number.
- 4) **Fax Number:** Please provide a facsimile number where we may be able to fax information or documents to you. If you do not have a fax, you may skip this item.
- 5) **International ACH Transaction:** The National Automated Clearing House Association (NACHA) requires International ACH Transactions (IAT) be identified. In order to comply with these rules we must ask you to check the appropriate box that applies. Check the top/first box if the entire amount of the direct deposit IS ultimately deposited outside the U.S. Check the bottom/second box if the entire direct deposit is NOT ultimately deposited outside the U.S.
- 6) **Email Address:** Provide an email address to receive notification each time a payment is made, and other pertinent information, as may be needed.
- 7) **Name and Address:** We must have your company or organization name if you are a business. If you are an individual home based child care provider, or a sole proprietor, we must have your individual name. Also, since there is a small possibility that a payment may have to be mailed to you, an address must be provided. For center based and home based child care providers, this is the mailing address where you receive payments against your invoices.

Section B

- 1) **Type of Account:** Specify if Checking or Savings and if Personal or Commercial.
- 2) **ABA Routing or Transit Number:** This is always a nine-digit number. See the check numbering example below.
- 3) **Depositor Account Number:** This may have up to seventeen digits. See the example below.

Check Number: This may be located to the right of the account number. Please see the example below.



Section C - Child Care Providers (Payees) must complete the information regarding their Financial Institution (Bank, Credit Union, etc.)

Read and sign the form to indicate your agreement with the terms and conditions specified on it. Note that by submitting the form you are authorizing **GAP Solutions, Inc.** to credit your account (deposit funds) and, in the event of an overpayment error, to debit your account (withdraw funds) for the amount of the over-payment.

All of the individuals named on a Consumer or Personal Account must sign this form. If held by more than one person, the joint account holder must also authorize these EFT transactions. If your commercial or business account requires two (2) persons to sign a check or a withdrawal, then those same two (2) persons must sign this form.