North Carolina Department of Health & Human Services
State Treasurer's Electronic Payments System (STEPS)
EFT Authorization Form

Check One: Initial Signup	Change	Effective Date:

PARTICIPATING ENTITY INFORMATION

ID # : _____ (Assigned by Department of Health & Human Services)

Entity Name: _____

Entity Address: _____ Fax # : ( ) _____

FINANCIAL INSTITUTION ACCT. INFO.:

STEPS OUT (Payments From State)	**STEPS IN (Payments To State)**
Institution Name:	**Institution Name:**
Institution Address:	**Institution Address:**
Transit/Routing #	**Transit/Routing #**
Bank or NCCMT Acct. # **(includes any leading zeros)**	**Bank or NCCMT Acct. #** **(includes any leading zeros)**
Type of Acct.: ___ Checking ___ Savings **NCCMT (Check One)**	**Type of Acct.: ___ Checking ___ Savings** **NCCMT (Check One)**

PARTICIPATING ENTITY AUTHORIZATION:

I, on behalf of the participating entity indicated above, hereby authorize the North Carolina State Treasurer, his successors and his agents, at the direction of the North Carolina Department of Health & Human Services (DHHS), to:

For STEPS-OUT: initiate ACH credit entries to the above designated bank and/or NCCMT account for payments due from DHHS for all payment types designated by the State Controller as being "required" to be remitted via EFT, pursuant to the "Established Operational Procedures For State Treasurer's Electronic Payments System," which may be in effect from time to time. I (we) also authorize any necessary ACH debit entries or adjustments for any ACH credit entries made in error to the account; and/or

For STEPS-IN: (a) redeem shares of the above designated NCCMT account and to instruct the NCCMT, its transfer agent, or any of their agents to send the proceeds of such redemptions to any account designated by the State Treasurer; and/or (b) initiate ACH debit entries against the designated bank account, for moneys due DHHS for all payment types designated by the State Controller as being "required" to be collected via EFT, pursuant to the "Established Operational Procedures For State Treasurer's Electronic payments System," which may be in effect from time to time.

This authorization is to remain in full effect until the Department of Health & Human Services and State Treasurer have received written notification from me of its termination.

Finance Officer's Name: _____ Tel: _____

Signature Date:

MAIL COMPLETED FORM TO:	**DHHS Use Only**	**State Treas. Use Only:**
NC DHHS, Controller's Office Program/Benefit Payments 2019 Mail Service Center Raleigh, NC 27699-2019		