DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS)

Payment Information Form

The information requested on this form is needed to electronically transfer competition award amounts to your account at your financial institution. To receive such a payment, you must provide certain information about your financial institution, your account at that institution, and yourself.

Privacy Act Statement

The following information is provided to comply with the privacy act of 1974 (P.L. 93-579). Information collected on this form is required under the provisions of 31 USC 3322 and 31 CFR 210. This information will be used by the Treasury Department to transmit payment data by electronic means to your financial institution. Failure to provide the requested information may delay or prevent the receipt of award payments through the automated Clearing House Payment System.

Check one: ☐ Federal Employee ☐ Contractor and Other Entities ☐ Individuals

Name ____

Address ____

____

Telephone (____) ____________________

Complete one of the following: (*May be your social security number if you are an individual.)

EIN* (Employer ID#) __________________________ TIN (Tax ID#) ___________________________

Financial institution information:

1. Name of financial institution ____
2. Address of financial institution ____
3. Financial institution's 9-digit ABA routing # for transfer of funds: ☐☐☐☐☐☐☐☐☐
4. Depositor account title ____
5. Depositor account number ____
6. Type of account: ☐ Checking ☐ Savings

The following is to be completed by payee.

I have verified that the information on this form is accurate and assert that it is appropriate for the payment of competition award funds to be deposited into the account specified above.

Printed Name: ________________________________ Date _________________________

Title (as appropriate): __________________________

Signature: __________________________________

NOTE: ALL THE ABOVE INFORMATION MUST BE PROVIDED AND SIGNATURE IS REQUIRED.