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

PLEASE SCAN TO ACCOUNTING@ELCMDM.ORG

	Type of Entry:	NEW	CHANGE	
Name of Facility:				
Address:				
City, State, Zip Code:				
Tax ID OR SSN:		DCF LIC Number:		
Phone Number:				
Director/Owner:				
	PLEASE CO	OMPLETE THE FOLLOWING SECTION	DN:	
Counties, hereinafter the	he COMPANY, to	credit entries to our account	g Coalition of Miami-Dade/Monroe indicated below and the financial 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	
PROVIDER of its term	nination and such	time and manner as to affor	received written notification from d the COMPANY and FINANCIAL nformation in this form is correct.	
X	D		Det	
Authorized Signature of	rroviaer/Owner	-	Date	
PLI	EASE ATTA	CH COPY OF VOIDI	ED CHECK	