LDSS-5025 (Rev. 7/15)

NYS OTDA State Supplement Program (SSP)

Direct Deposit Enrollment Form

Directions:

- To be completed by individuals who receive only SSP benefits. Individuals receiving federal SSI benefits need to contact SSA.
- Complete this form **ONLY** if you wish to enroll in Direct Deposit. **BOTH** sections must be completed.
- Return the completed form to: **NYS OTDA State Supplement Program, PO Box 1740, Albany NY 12201;** or by **FAX** to: 518-486-3459; or **Email** the **hand signed** form to otda.sm.ssp@otda.ny.gov
- Please contact the **SSP Customer Support Center at 1-855-488-0541** with any questions**.**

The following information must be provided. If ANY information is missing, the form will be returned for completion.

Recipient Name _____ **Daytime Phone Number (**____) _____-_____
Last *First* *MI*

Recipient Mailing Address _____

City _____ State _____ Zip Code _____

Date of Birth (MM/DD/YYYY) ____ / ____ / _____ Last Four Numbers of SSN **XXX** -**XX**-_____

I certify that I am entitled to the benefits associated with the NY State Supplement Program (SSP). In signing this form, I authorize the SSP to send my benefits to the financial institution named below to be deposited into the account indicated by the financial institution. This authorization will remain in force until I provide written notice of termination.

Print Name_____ **Signature** _____ **Date** _____

ACCOUNT INFORMATION

Please take this form to your bank or credit union for the completion of the information below. You may also choose to attach a voided preprinted (not starter) check containing your name and address or an account deposit form containing your name and address.

This **CANNOT** be a Trust Account to benefit another OR a Foreign Financial Institution Account

Account Information: ☐ Checking ☐ Savings

Name on Account: _____ Relationship to Recipient: _____

Bank Information**:** Name of Financial Institution (bank or credit union): _____

Address _____ City_____ State_____ Zip_____

Account Number _____ Routing Transit Number_____

As representative of the above-named Financial Institution, I certify this financial Institution is ACH capable and will receive and deposit the benefit payment to the account shown above in accordance with Part 102 of the Codes, Rules, and Regulations of the State of New York and to be bound by such rules. Payments credited to the account above will be available to the depositor immediately.

_____ _____ _____
Representative Signature **Representative Printed Name** **Date**