



Direct Deposit Authorization Agreement

I hereby authorize Rocky Mountain Health Care Services (RMHCS) to deposit any amounts owed me by initiating credit entries to my bank account without liability for correctness of entries. Further, I authorize the financial institution indicated below to accept and to credit any entries initiated by RMHCS to my account. If RMHCS deposits funds in error to my account, I authorize RMHCS to debit my account for an amount no greater than the original error.

Contractor Name: _____

EIN: _____

Begin Direct Deposit

Change Information

Cancel Direct Deposit

Bank Name: _____ Check one: Checking Savings

Email address for remittance: _____

Please attach void check or letter from bank with your bank's routing number and your account number and submit with this form to Accounting.

This authorization is to remain in effect until RMHCS receives two weeks' written notice from me of termination or change. If I fail to notify RMHCS of account closure, I will be responsible for any fees incurred by RMHCS.

Contractor Signature: _____ Date: _____