Provider Resources Inc.
Provider's Food Program

DIRECT DEPOSIT AUTHORIZATION FORM

This form must be completed and returned to Provider Resources, Inc. before direct deposit of your food program reimbursements may occur. This form MUST be accompanied with some form of proof of your routing and account numbers for the given account. It must be a pre-printed form of proof. Nothing handwritten will be accepted. For a checking account, this should be a voided check. For a savings account, this may be a Pre-Printed savings deposit slip. A "Direct Deposit Application" can also be obtained from your bank and can be used, but you must fill this form out as well. This form may also be used to change your direct deposit, or to cancel your direct deposit account. Before completing this form, please make sure you understand the terms and conditions of the agreement. Fill in the boxes below and sign the form. When completed, please mail the form to the address above. Please allow one month from submitting the form for the direct deposit to take affect.

Last Name **First Name** **MI**

Social Security Number **Phone Number**

New **Change** **Cancel**

Effective Date
Month Day Year

Name of Bank

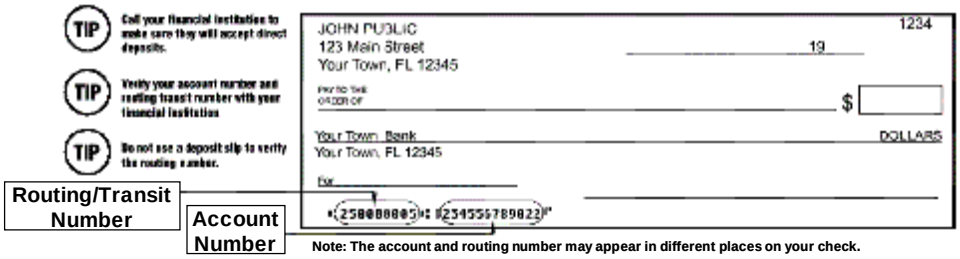
Account Number

Type of Account
Checking Savings

Routing/Transit Number

(All 9 digits must be filled in. The first two numbers must be 01 through 12 or 21 through 32)

Ownership of Account
Self Joint Other



Note: The account and routing number may appear in different places on your check.

I authorize Provider Resources, Inc. to pay my food program reimbursements by direct deposit to the financial institution designated above, and also for the financial institution to credit the deposit to my account. I also authorize Provider Resources, Inc. to obtain information from my financial institution pertaining to this direct deposit agreement, and to debit my account if the payment was credited in error and corrections need to be made. I recognize that if I fail to provide complete or accurate information on the direct deposit authorization form, the processing of this form may be delayed and/or my payments may be erroneously transferred. In the event that funds are erroneously transferred due to my failure to provide complete or accurate information on this form, I do not hold Provider Resources, Inc. responsible for the recovery of such erroneous transfers, not withstanding any reasonable attempts made by Provider Resources, Inc. to correct such errors.

I certify that I have read and understand the terms and conditions of this form. By signing this agreement, I authorize Provider Resources, Inc. to initiate credit and/or debit entries to the account indicated above for the purpose of reimbursements for my child care services.

Signature:_____ **Date:**_____

If the account is a joint account or in someone else's name, that individual must also agree to the terms stated above by signing below.

Signature:_____ **Date:**_____

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