INSTRUCTIONS FOR COMPLETING
THE AUTHORIZATION AGREEMENT FOR DIRECT DEPOSIT

PLEASE TYPE

SECTION 1

A Enter X above the type of transaction:

Add	indicates a new authorization
Change	indicates a change to an existing authorization
Delete	indicates a request for termination of direct deposit

B Enter the complete name and address of the public office or entity to receive direct deposit.

C Enter your Federal Tax Identification of you office or agency.

D Enter email address.

SECTION 2

A Enter the name and address of the ACH member financial institution authorized to conduct transaction. The requirements of the Uniform Depository Act. Chapter 135 of the Ohio Revised Code, are applicable to EFT banking transactions.

B Enter the financial institution's Transit Routing/ABA number in the space provided. This is a nine digit number that is shown on your check. It may also be obtained by contacting your financial institution and requesting its Transit Routing/ABA number.

C Enter the account number to which the EFT transactions are to be accredited.
Enter X above the type of account to which funds are to be deposited.
It you elect to deposit in a checking account, please attach one of your checks with the signature space marked **VOID**.

This authorization form must be signed and dated by the financial officer authorized to conduct banking transactions for said provider.

Forward the signed authorization form with voided check to:

Area Agency on Aging District 7, Inc.
PO Box 154
160 Dorsey Drive
Rio Grande, Ohio 45674-0154

If you have any questions, call (740)245-5603 or 1-800-582-7277.

Authorization Agreement for Direct Deposit
Provider Reimbursement

I _____ (Print Provider Name), hereby authorize the Area Agency on Aging District 7, Inc. (AAA7) to initiate credit entries to our account and also debit entries, if necessary, for any credit entries that are determined to be in error. We additionally authorize the financial institution to credit or debit the same to our account.

Please TYPE OR PRINT all information, sign, date and return to the Area Agency on Aging on Aging District 7, Inc.

SECTION 1

A Type of Transaction: _____ Add _____ Change _____ Delete

B _____ NAME OF APPLYING ENTITY _____ COUNTY

C _____ FEDERAL TAX ID NUMBER _____ (AREA CODE) TELEPHONE

D _____ EMAIL ADDRESS

SECTION 2

A _____ FINANCIAL INSTITUTION NAME _____ COUNTY _____ (AREA CODE) TELEPHONE

_____ ADDRESS _____ CITY _____ STATE _____ ZIP COPE

B _____ TRANSIT ROUTING/ABA NUMBER

C _____ ACCOUNT NUMBER AT ABOVE INSTITUTION TYPE OF ACCOUNT _____ CHECKING _____ SAVINGS

Any account changes must be reported to our office thirty (30) days prior to actual change.

This authority is to remain in full force and effect until AAA7 has received written notification from us of its termination in such time and in such manner as to afford AAA7 and the depository a reasonable opportunity to act on it.

_____ EXECUTIVE DIRECTOR SIGNATURE

_____ TITLE

_____ TYPE NAME

_____ DATE