



AUTHORIZATION FOR DIRECT DEPOSIT (ACH)

I authorize Community Care to initiate entries to _____'s
Checking/savings account indicated below and the financial institute named below to credit and
or debit the same to such account.

(NAME OF FINANCIAL INSTITUTION)

(BRANCH)

(CITY)

(STATE)

(ZIP CODE)

(SIGNATURE)

(DATE)

(NAME- PLEASE PRINT)

(TITLE)

(S.S.N. or TAX ID)

Account No. _____ Checking Saving

Financial Institution Routing Number _____

This authority is to remain in full force and effect until Community Care has received written notification from the above company in such time and in such manner as to afford Community Care and the financial institution named above a reasonable opportunity to act on it.

Return this form and a cancelled or voided check to:

**Community Care Family Care
ATT: Provider Management Department
1801 Dolphin Drive
Waukesha, WI 53186
Or
FAX: 262-446-6707**