



**PLACEMENT RESOURCE PROVIDER
DIRECT DEPOSIT AUTHORIZATION FORM**

Provider Name: _____

Address: _____

Phone: _____

I authorize Cornerstones of Care to provide payment through direct deposit to the account below. This authorization shall remain in effect until revoked in writing.

Authorizing Signature: _____ **Date:** _____

Bank Name: _____

Address: _____

Account Number: _____ **Account Type:** _____

Bank Routing Number: _____

Attach Voided Check Below: