NWF Health Network

Big Bend Community Based Care, Inc.
DBA NWF Health Network

Electronic Funds Transfer (EFT) Authorization

525 North Martin Luther King Jr. Blvd, Tallahassee, FL 32301
Office: 850-410-1020 Fax 850-921-9718

To start or change an EFT Authorization, a voided check or a letter from your bank to include your name, routing number and account number, drafted on banks letterhead must be attached.

PLEASE STAPLE HERE

Last Name:	First Name:	M.I. :	
Street Address:	City:	State:	Zip Code:
Vendor Social Security Number (EID): - -	Email Address:	Telephone Number: ( ) -	
First and Last Name of Child(ren) in Care:	Please identify which subsidy(ies) you are requesting for direct deposit: ☐ Adoption Subsidy ☐ Foster Family Support		

☐ START	☐ CHANGE	☐ STOP
Allow two (2) weeks for processing. Verify your first EFT with a representative of your bank.	Allow two (2) weeks for processing. **For the first payment, you will receive a check at your payment address.** The second payment will be directly deposited to your account. Verify this deposit with a representative of your bank to ensure an accurate set-up of this transaction.	A complete and signed EFT Authorization **must be received at the BBCBC Accounting Office 14 days prior to the next payment.**

Type of Account - CHECK ONE: ☐ Checking ☐ Savings	Bank Name

☐ I UNDERSTAND THAT I MUST SUBMIT A NEW EFT AUTHORIZATION FORMIFICHANGEBANKS AND/OR ACCOUNTS.
(No other notices are needed if this form is used.)

I authorize Big Bend Community Based Care, Inc. DBA NWF Health Network to transfer my payment to the financial institution named above for deposit to my account.

I understand that if I close my account, I will not receive a payment until my bank returns the funds to the agency. The Agency is authorized to terminate this agreement without notice if legally obligated to withhold any part of my payment. This authorization remains in effect until I notify the NWF Health Network Accounting Dept. in writing.

Vendor's Signature _____ **Date** _____

Vendor's Signature _____ **Date** _____

Please provide a copy of your valid driver's license as proof of verification when submitting this form.