ASA - Direct Deposit Authorization

Choose: _____Member _____Residential Provider

Location: _____GJ _____DR _____CS

I authorize Ariel Clinical Services to send credit entries, as well as appropriate adjustments and debit entries, to my/our account as indicated below.

Account Type: _____Checking _____Savings Institution

Name: _____ Bank

Routing #/ ABA #: _____

Account#: _____

Account verification must be submitted with this form, and not in lieu of it.

Please Attach:
Voided Check or Account Verification Form/Letter issued by your bank.

Verification must include:

1. Bank Letterhead/Logo, Address and Routing Number
2. Name on Account, Account Number, Type of Account

Signature: _____Date: _____

Printed Name: _____

Email Address for Notifications (optional): _____