



DIRECT DEPOSIT
AUTHORIZATION FORM
Community Coordinated Care for Children Inc.
3500 W. Colonial Dr. Orlando, FL 32808

Provider Name: _____

Name of Bank: _____

Bank's Address _____

City: _____ State: _____ Zip: _____

Checking Acct. Number: _____

(Attach a voided check and/or deposit slip)

ABA Routing Number: _____

Savings Acct Number: _____

(Attach a deposit slip)

Name of Bank: _____

Bank Address: _____

City: _____ State: _____ Zip: _____

ABA Routing Number: _____

The bank routing number (ABA) is printed on your checks in the lower left hand corner
next to the account number

I, _____, hereby authorize Community Coordinated Care for Children, Inc. to directly deposit my Reimbursement and/or VPK prepayments into the bank account(s) identified above.

Provider Signature: _____ Date: _____

CASH PAY CARDS ARE AVAILABLE. PLEASE CONTACT 4C AT 407-532-4129 OR 407-532-4120 FOR MORE INFORMATION.