

State of Oregon  
**Direct Deposit Authorization Form**  
 For Receiving Payment By  
 Electronic Funds Transfer (EFT)



SFMS Website: [http://oregon.gov/DAS/SCD/SFMS/docs/forms/ACH\\_enrollment\\_form.doc](http://oregon.gov/DAS/SCD/SFMS/docs/forms/ACH_enrollment_form.doc)

**SECTION A**

Instructions are on Page 2

1. TYPE OF ACTION a <input type="checkbox"/> NEW  b <input type="checkbox"/> CHANGE  c <input type="checkbox"/> CANCEL	2. SSN / FEIN / OR#  3. PHONE NUMBER  4. USERID (Create, 7 or 8 Characters)	6. EMAIL ADDRESS (for payment notification)  7. PAYEE NAME AND MAILING ADDRESS
5. INTERNATIONAL ACH TRANSACTION (NACHA requirement): <input type="checkbox"/> The entire amount of my direct deposit payment IS ultimately deposited to a financial institution outside the U.S. <input type="checkbox"/> The entire amount of my direct deposit payment IS NOT ultimately deposited to a financial institution outside the U.S.		

**SECTION B**

**Important! Please read and sign before submitting.**

**CANCELLATION / CHANGE OF ACCOUNT**

The agreement represented by this authorization remains in effect until canceled in writing by the payee or until the program is suspended or terminated by the State of Oregon. Payments to you will be deposited into the account designated below until ACH Coordinator is notified in writing that you wish to cancel this authorization or designate a different Financial Institution or account. Six to ten banking days are needed to execute your instructions. To make any changes, submit a new form (SFMS ACH-1) with the updated information. If any action or inaction taken by the payee results in non-acceptance of an EFT deposit by the designated Financial Institution, payee acknowledges that the State has no responsibility to issue another payment until the funds for the non-accepted deposit are returned to the State by the Financial Institution. If non-acceptance by the Financial Institution is the result of action or inaction taken by the payee, late fees and penalties including consequential damages caused by this non-acceptance do not apply. Please **DO NOT CLOSE YOUR ACCOUNT UNTIL ONE WEEK AFTER NOTIFYING ACH Coordinator**.

**RECOVERY OF FUNDS DEPOSITED IN ERROR**

In the event that an erroneous EFT payment occurs, creating an over-payment, the State reserves the right to debit your account for an amount not to exceed the amount of the erroneous EFT payment. In the event that a debit adjustment cannot be implemented, the State and/or Agency Office may utilize any other lawful means to recover payments to which the account holder is not entitled, including deducting the amount owed from future payments until the total over-payment is recovered. By signing this form, account holder(s) acknowledge their acceptance of these terms and conditions.

**I/We certify that I/we have read and understand** the information contained in Section B, above. I/We authorize the State of Oregon, through the State Treasury, to deposit payments and make over-payment adjusting debits to my/our account as designated below. I certify that I am authorized to enter into this agreement on behalf of the account holder.

1.	<b>X</b>	Print Name	Title (if company account)	Date
	Signature of Account Holder			
2.	<b>X</b>	Print Name	Title (if company account)	Date
	Signature of Joint Account Holder			

**SECTION C - FINANCIAL INSTITUTION INFORMATION** (To be completed by Financial Institution Representative)

1. ACCOUNT TYPE (1): a. <input type="checkbox"/> SAVINGS b. <input type="checkbox"/> CHECKING		ACCT TYPE (2): c. <input type="checkbox"/> PERSONAL d. <input type="checkbox"/> COMMERCIAL	
2. ABA ROUTING & TRANSIT NUMBER	3. DEPOSITOR ACCOUNT NUMBER	4. ACCOUNT NAME (for commercial accounts)	
5. FINANCIAL INSTITUTION NAME		6. FINANCIAL INSTITUTION TELEPHONE NUMBER	
7. FINANCIAL INSTITUTION ADDRESS			
(Number and Street)		(City)	(State) (Zip)
I have verified the signature(s) and account numbers above. This Financial Institution is ACH capable and will comply with NACHA rules. ACH payments credited to the above account will be available to the account holder at the start of the Financial Institution's business day on the settlement date established by the ACH Operator. SFMS will accept Agency Payroll Officer signature for State Employees.			
8. Representative's Name (Printed or Typed)	9. Signature of Representative	10. Telephone Number ( ) -	11. Date - -

**SECTION D - FOR DAS/SCD/SFMS USE ONLY**

1. Vendor No. and Mail Code	2. Pre-note Date	3. NACHA Format PPD+ CCD+ CTX	4. Notes
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