Center for Disability Rights, Inc.

497 State Street Rochester, New York 14608 (585) 546-7560 V/TTY (585) 546-7567 FAX
PooledTrust@cdrnys.org

Community Supplemental Needs Trust

Direct Deposit Form
(Please attached a VOIDED check)

1. Name and address of the beneficiary:

2. Email Address (*optional*): _____

3. Do you want CDR to pull this amount [ ] **ONE TIME Immediately** *-If you selected* ***Immediately*** *CDR will pull the funds from your account when we receive the form*

   and/or [ ] **Each Month**

   Is this a new or revised request? _____ **NEW** _____ **Revised**

4. If you selected **Each Month** above what day of the month: _____

5. For **EACH month what month** do you want to start it in: _____

6. Amount Requested: $_____

7. Bank Routing Number (*9 digits*): _____

8. Bank Account Number: _____

_____ _____
Signature of beneficiary or legally responsible person Date

By signing this form, I attest that I agree to have the Center for Disability Rights withdraw the amount stated immediately or on the date I indicated each month. I understand that it could take up to 3 days for the ACH to fully process and that I will only have access to the funds after the funds have fully cleared. ***I also agree to pay any fee that might result from a NSF or an ACH Revoke/Unauthorized Fee.***

FOR INTERNAL USE ONLY

RECEIVED		ENTERED