New Jersey State Department of Health
HEALTH CARE SUBSIDY FUND
PO Box 360
Trenton, NJ 08625-0360

AUTHORIZATION AGREEMENT FOR AUTOMATIC PAYMENTS/DEPOSITS

State Name	Facility Name and Address
New Jersey State Department of Health **Health Care Subsidy Fund /** ***AMBULATORY CARE ASSESSMENT***	

I (We) hereby authorize the New Jersey State Department of Health hereinafter called **STATE**, to initiate debit/credit entries to the ambulatory care facility's checking account indicated below, and the depository named below, hereinafter called **DEPOSITORY**, to debit/credit the same to such account.

All such debits/credits shall be made in accordance with the requirements of P. L. 2010, c. 23 as amended which stipulates that the uniform gross receipts assessment shall be applied at the rate of 2.95% to each facility subject to the assessment, for deposit in the Health Care Subsidy Fund.

Depository Name	Branch	
City	State	Zip Code

Bank Transit/ABA Number	Account Number

This authority is to remain in full force and effect until **STATE** has received written notification from the facility's authorized agent of its termination in such time and in such manner as to afford **STATE** a reasonable opportunity to act on it.

Name of Authorized Agent (1)	Title
Signature	Date
Name of Authorized Agent (2)	Title
Signature	Date

Facility License Number	Telephone Number(s)	Email Address

Distribution: Original – Facility
Copy – State of New Jersey

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