



DP-156-ACH
Nursing Facility Quality Assessment
Authorization Agreement for
Pre-Authorized Payments

STEP 1 FACILITY NAME & ADDRESS	NURSING FACILITY NAME		FEDERAL EMPLOYER IDENTIFICATION NUMBER
	NUMBER AND STREET ADDRESS		
	ADDRESS (continued)		
	CITY/TOWN STATE & ZIP CODE		
STEP 2 INITIAL, CHANGE, OR REVOCAION	Check the type of request: <input type="checkbox"/> INITIAL REQUEST <input type="checkbox"/> CHANGE REQUEST <input type="checkbox"/> REVOKE AUTHORIZATION		
STEP 3 DEPOSI- TORY INFORMA- TION	DEPOSITORY (BANK) INFORMATION		
	Depository (Bank) Name	Depository (Bank) Routing & Transit #	
	Name on Depository Account	FEIN/SSN on Depository (Bank) Account	
	Depository Account Number	Account Type (check one)	<input type="checkbox"/> Savings <input type="checkbox"/> Checking
	YOU MUST PROVIDE A COPY OF A VOIDED CHECK OR A SAVING WITHDRAWAL SLIP FOR THIS ACCOUNT.		
STEP 4 ACH AUTHO- RIZATION	This authorization is to remain in full force and effect until the STATE has received written notice from me (or either of us) of its termination in such time and in such a manner as to afford the STATE and DEPOSITORY a reasonable opportunity to act on it. By signing below, I hereby authorize the State of New Hampshire Treasury to initiate variable debit entries to the bank account and the depository named above.		
	PRIMARY NAME		TELEPHONE #
	SECONDARY NAME		TELEPHONE #
STEP 5 SIGNATURES	By signing below, I hereby authorize the State of New Hampshire Treasury, to initiate debit entries to our Checking or Savings account indicated above at the depository (bank) named above, to debit the same to such account.		
	SIGNATURE (IN INK) OF AUTHORIZED OFFICER/REPRESENTATIVE		
	PRINT SIGNATORY NAME & TITLE		DATE
	<table border="1"> <tr> <td> NH DRA MAIL TO: ADMINISTRATION UNIT PO BOX 457 CONCORD, NH 03302-0457 </td> </tr> </table>		
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FOR DRA USE ONLY



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GENERAL INSTRUCTIONS

WHO MUST FILE

All nursing facilities in New Hampshire. Nursing facility means all nursing facilities licensed by the New Hampshire Department of Health and Human Services as defined by RSA 151-E:2,V, and facilities licensed as a specialty hospital and certified to receive federal reimbursement as a nursing facility.

WHAT TO FILE

A completed DP-156-ACH and a copy of a voided check or savings withdrawal slip for this account.

WHEN TO FILE

ACH Debit authorization must be received by the New Hampshire Department of Revenue Administration (NH DRA) 30 days prior to (1) the first filing of Form DP-156, Nursing Facility Quality Assessment Return; (2) any time there is a request for change or revocation.

EFFECTIVE DATE OF ACH DEBIT

The ACH payment will be debited 2 days prior to the last business day of the month following the due date of the return or (if under extension or alternative payment agreement), on such date as approved by the Commissioner of Revenue Administration.

WHERE TO FILE

Completed authorization forms shall be filed with NH DRA for recording and then will be forwarded by the NH DRA to the NH Department of Treasury for processing.

REQUEST TO REVOKE AUTHORIZATION

All written debit authorizations must provide that the Receiver (Nursing Facility) may revoke the authorization only by notifying the Originator (NH DRA) in the manner specified in the Authorization. The Receiver (Nursing Facility) must be given a copy of their written debit authorization by the NH Treasury.

PRENOTE TEST

An ACH Debit "Prenote Test," as defined in REV 2501.13, is required for the initial request and any changes.

LINE BY LINE INSTRUCTIONS

STEP 1

Enter the Nursing Facility name, address and Federal Employer Identification Number in the spaces provided.

STEP 2

Check the appropriate box to indicate whether this is an initial request, a change request, or a request to revoke ACH Debit Authorization.

STEP 3

Enter the Depository (Bank) information in the spaces provided. It is important to enter all digits of the routing and account number for accurate processing.

STEP 4

The Nursing Facility must provide a primary and a secondary name and telephone number for questions concerning ACH Debit Authorization. The facility shall file a change form whenever the primary or secondary contact person changes.

STEP 5

By signing, the authorized representative authorizes the NH Department of Treasury to debit their bank account by the amount reported to the NH Department of Revenue Administration on the Form DP-156.