OUTREACH HEALTH CARE
ACH DEPOSIT AUTHORIZATION

In lieu of delivering check payments directly to the undersigned, we hereby authorize Outreach Health Care, and all Subsidiaries, to initiate credit entries to the account indicated below (the "ACCOUNT") and the depository named below (the "DEPOSITORY") to credit such payments to the ACCOUNT.

In the event of overpayment to the ACCOUNT, the undersigned grants Outreach Health Care and the DEPOSITORY the right to make an adjusting debit entry to the ACCOUNT, not in excess of the amount of such overpayment.

Depository (BANK): _____ Branch: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Account in the name of: _____ Acct.#: _____

Checking Acct.: _____ or Savings Acct.: _____ Bank Routing #: _____

Indicate if your financial institution is a Credit Union: _____ or Savings & Loan: _____

This authority may be terminated upon thirty day's prior written notice thereof from the undersigned to the OHC AP Department.

Company Name _____

Address_____

Signature_____

FAX TO: 800-687-3121

MAIL TO: Outreach Health Services, P.O. Box 945, Osceola, WI 54020