DIRECT DEPOSIT
AUTHORIZATION AGREEMENT

I hereby authorize All Saints Home Care, Inc., to initiate credit entries to my account as indicated below at the financial institution named below and to credit the same to such account. I acknowledge that the organization of ACH transactions to my account must comply with the provisions of U.S. law.

TYPE OF ACCOUNT (Check one): ☐ Checking or ☐ Savings

Financial Institution: _____

Branch Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Routing Number: _____

Account Number: _____

Email address: _____
(You will receive an invite to the Self-Service Portal)

This authorization is to remain in full force and effect until All Saints Home Care, Inc. has received A Change of Pay Form from Me. Forms are available at the office. Please allow up to 10 days for processing.

☐ New Direct Deposit ☐ Replace Existing Direct Deposit

Name: _____ **DOB**: _____ **SSN:** _____
(PLEASE PRINT CLEARLY)

SIGNATURE_____ **DATE:** _____

***PLEASE ATTACH A VOIDED CHECK ***

AND ALLOW 1- 10 DAYS FOR PROCESSING.

FOR OFFICE USE ONLY:

Input: _____ **Date:** _____ **Audit:** _____ **Date:** _____

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