DIRECT DEPOSIT FORM

Sign, date and fax form to: (888) 401-7847

ALSO: MUST ATTACH VOIDED CHECK

Caregiver Full Name: ___________________________________

Telephone #: ____

Address: ____

Authorization Agreement

I hereby authorize Care Indeed to initiate automatic deposits to my account at the financial institution named below. I also authorize Care Indeed to make withdrawals from this account in the event that a credit entry is made in error.

Further, I agree not to hold Care Indeed responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until Care Indeed receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Payroll Department.

Account Information

Name of Financial Institution: ____

Routing Number: ____

Account Number: ____ ◯ Checking | ◯ Savings

Signature

Authorized Signature (Primary): ____ Date: ________________

Authorized Signature (Joint): ____ Date: ________________

**After we receive, please allow up to 2 weeks for direct-deposit to take effect*