



CHILD CARE RESOURCE AND REFERRAL AGENCY

CACFP DIRECT DEPOSIT

Date: _____

I, _____, have received the necessary information concerning Direct Deposit and made the decision to participate in this program offered by the Sullivan County Child Care Council, CACFP Program.

I understand that only one information change (Bank Deposit, etcetera) can be made each year.

Provider's signature: _____

Staff's Signature: _____



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Direct Deposit Authorization Form

I hereby authorize the Sullivan County Child Care Council, Inc./CACFP, to initiate direct deposit credit (and/or debit) entries. This authority is to remain in full force and effective until written notice is given, with reasonable opportunity to act:

Name (Print)	Signature	Date
Financial Institution Name	Financial Institution Address	SS #
Bank account #	Routing #	Checking or Savings account

****FEDERAL REGULATIONS REQUIRE THE BANK ACCOUNT BE IN THE NAME OF THE *INDIVIDUAL* PROVIDER**

Due to the time required, allow one to two pay periods for processing. You will receive a regular check until the change can be completed.

I am ***not*** currently participating in the Direct Deposit Program

___ Add—Deposit my pay to the **account shown**.

One of the following is required to process this enrollment:

****Checking account**

___ *Voided check with name imprinted (no starter checks), OR

___ *Deposit slip (only if ACH R/T appears before routing #

OR

****Savings account**

___ *Bank letter or specification sheet (including signature of local bank representative

 :: ***Attach required documents**

I am ***currently*** participating in the Direct Deposit Program

___ Change my Financial Institution and/or account number.

___ Cancel my participation in the program.

Confirmation

I authorize this document and agree that direct deposit transactions comply with all applicable law. My signature indicates that I am the account holder indicated:

X_____ Date_____