A B B E Y C A R E , I N C.
H O M E H E A L T H C A R E A G E N C Y
A B B E Y C A R E C H O I C E , I N C.
P E R S O N A L C A R E P R O V I D E R

DIRECT DEPOSIT AUTHORIZATION FORM

Please print clearly

Employee Name ____

Employee SS # _______________________ Telephone # __________________________

Account Type (select one) Checking ___ Savings___

Bank ____

Bank Address ____

City __________________________ State _________ Zip _____________________

Note: The bank selected to receive the Direct Deposit must be a member of the National Automated Clearing House Association (NACHA). Please contact your bank if you are not sure if they are a member of NACHA.

Please attach voided check
or
A letter printed from the bank with checking and routing information

Handwritten account and routing numbers will not be accepted.

I, ____ , authorize AbbeyCare, Inc. to initiate credit entries and correcting debit entries, if necessary, to the bank account noted above, and to deduct **$0.25 per paycheck** to cover AbbeyCare, Inc. expense for the direct deposit processing. This authority is to remain in full force until AbbeyCare, Inc. has received written notification from me of its termination. Written termination shall be received in such time as to afford AbbeyCare, Inc. and the bank a reasonable opportunity to act on it.

Signed ____ Date _______________

1148 Grand Ave St. Paul, MN 55105
www.abbeycareinc.com
T E L E P H O N E N U M B E R : 6 5 1 - 6 9 0 - 5 3 5 2
F A X N U M B E R: 6 5 1 - 2 0 9 - 8 0 6 5