ABBEYCARE, INC.
HOME HEALTH CARE AGENCY
ABBEYCARE CHOICE, INC.
PERSONAL CARE PROVIDER

DIRECT DEPOSIT AUTHORIZATION FORM

PLEASE PRINT CLEARLY

Employee Name: _____

Employee SS#: _____Telephone #: _____

Account Type (select one) Checking: _____ Savings: _____

Bank: _____

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 a Voided Check
Or
A letter, form or printout from the bank with
BANK NAME, YOUR NAME, ACCOUNT & ROUTING INFORMATION.
Handwritten account & routing numbers cannot be accepted.

This authority is to remain in full force until AbbeyCare, Inc has received a written notification from me of its termination. Written termination shall be received in such time as to afford AbbeyCare, Inc and the bank reasonable opportunity to act on it.

Signed: _____ Date: _____

ENTERED: _____

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1148 Grand Ave St. Paul, MN 55105
TELEPHONE NUMBER: 651-690-5352
FAX NUMBER:651-209-8065