CACFP PROVIDER DIRECT DEPOSIT AUTHORIZATION FORM

LEHIGH VALLEY CHILDREN'S CENTERS, INC.

Print Full Name: _____

I authorize Lehigh Valley Children's Centers, Inc., hereafter referred to as EMPLOYER, to deposit my periodic pay into my account identified as and held at the FINANCIAL INSTITUTION named above and I authorize that such account exists and that the FINANCIAL INSTITUTION can make deposits without responsibility for correctness of such amounts.

My authorization will remain in effect until I give a written notice to terminate this authorization to my EMPLOYER in sufficient time and manner as to allow my EMPLOYER to act upon it. In addition, either my EMPLOYER or the FINANCIAL INSTITUTION can terminate this agreement by providing me with their written notice at least 10 days prior to actual termination.

I have provided my EMPLOYER with a copy of a voided check solely for the purposes of verifying my account number and Financial Institution's routing number.

Employee Signature **Date**

Please note that, due to timing differences, new or changed direct deposit will receive one check after this form has been submitted

Name of Financial Institution:	**Financial Institution Routing Number:**
Account Number:	**Type of Account (Check One):** ☐ **Checking** ☐ **Savings**

PLEASE ATTACH A VOIDED CHECK IN THE SPACE BELOW

Reset Form