# Compassion Care In-Home Health

**Direct Deposit Information Policy Form**

**Client First and Last Name:**

**Caregiver First and Last Name:**

**Is this form a replacement for a previously submitted form?** ☐ Yes ☐ No

Compassion Care In Home Health LLC is committed to providing timely and accurate deliverance of the stipend pay for the caregivers. I, *(Caregivers Name)* that if any changes occur to my banking information, I have until the 15th of the current month to provide updated information for next month's stipend pay to be deposited into any new accounts. If it is after the 15th of the current month, there may be a delay in receiving next month's stipend pay, because my new banking information MUST be verified with the $.01 before any stipend pay deposits will be made from Compassion Care In Home Health LLC

Compassion Care In Home Health LLC is hereby authorized to directly deposit my stipend pay Into the above listed accounts), either the entire pay into one account or half into each of the two accounts. Furthermore, I authorize the financial institution(s) listed above to accept and to credit any entries by Compassion Care In Home Health LLC to my account. In the event that Compassion Care In Home Health LLC deposits funds erroneously into my account, I authorize Compassion Care In Home Health LLC to debit my account. This authorization will remain in effect until I change or cancel it in writing, or the services have been terminated or cancelled.

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**Bank Account Details:**

**Name of Bank:**

**Name on Account:**

**Please check if more then one name associated with the account:** ☐ Yes ☐ No

**Phone number associated with this account:**

**Bank Routing Number:**

**Bank Account Number:**

**Please check if:** ☐ Savings ☐ Checking

**Please check if:** ☐ The Whole Amount is acceptable ☐ Or you need a second bank account number.

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**Supply a copy of Check or Deposit Form:**

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***Client Signature:***

***Caregiver's Printed Name:***

***Caregiver's Signature:***