



MCFI Home Care Direct Paycheck Deposit Authorization Form

New Deposit Authorization Pay Card Aline ADP *request details if needed

Cancel Change Current Authorization

Employee Information:

Employee Name: _____ Social Security Number: _____

Address: _____ City _____, WI Zipcode _____

Telephone: _____ County that you live in : _____

Date of Birth: _____ Email address: _____

Effective Date: _____

Type of Account:

Checking Savings

Name of Financial Institution: _____

Bank Transit Routing Number: _____

Account Number: _____

I authorize MCFI Home Care and the financial institution(s) listed above to initiate deposits of funds to which I am entitled automatically into my account(s). If funds to which I am not entitled are deposited into my account, I authorize MCFI Home Care to direct the financial institution to return said funds. This authority will remain in effect until I make changes to the authorization. I understand that Direct Deposit or Pay Card Payment must be in place to receive paid compensation.

Employee Signature

Date

Important:

**Attach a voided check for each checking account that shows both the bank routing number and the account number to this form.*

**Direct Deposit will automatically be cancelled when your employment with MCFI Home Care ends. Your final pay check(s) will be a paper pay check(s) that will be mailed to the address MCFI Home Care has on file*

**Changes or cancellations must be submitted one week prior to next pay date. Changes or cancellations made after this time period will not be applied until the following pay date.*