Nutrition Program
A healthy start for life!

Direct Deposit Participation Agreement

Instructions:

1.) Complete the Authorization for Direct Deposits form.
2.) Write **"VOID" on one of your checks** and attach it to the Authorization for Direct Deposit.
3.) Read and sign this Direct Deposit Participation Agreement form.
4.) Submit all of these forms to:

CDA Nutrition Program
180 Otay Lakes Road, Suite 300
Bonita, CA 91902
Attention: Kathy Angel-Garcia

I understand that:

* I will continue to receive a check by mail until Direct Deposit is activated, which may take 4-6 weeks.

* Once activated my reimbursement will be sent electronically to my bank.

* I will receive a statement which will detail the meals and amount of my reimbursement and the amount deposited into my bank.

* To stop or change Direct Deposit transactions I will be required to submit a 30-day advance written notice to CDA's office.

* The name in which my reimbursement is listed matches the name on my license and therefore must match the bank depository information.

My signature below acknowledges my acceptance of Direct Deposits to my bank account for my CDA Nutrition Program (Child Care Food Program) reimbursements and I agree to the conditions for Direct Deposit as stated above.

_____	_____	_____
Provider Name (Print)	Provider Signature	Date

_____	_____	_____
Provider Address	City/Zip Code	Provider #

Only for office use

Date Received:	Date Entered:	Initial Verified Address & Provider Number:

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AUTHORIZATION FOR DIRECT DEPOSIT (ACH CREDITS)

Company Name ***Child Development Associates. Inc. Nutrition Program***	**CDA's Provider Number** **#**

☐ **Automatic Deposit,** I hereby authorize **CHILD DEVELOPMENT ASSOCIATES, INC., NUTRITION PROGRAM,** hereinafter called **COMPANY**, to initiate credit entries and to initiate, if necessary, debit entries and adjustments for any credit entry error to my:

- ☐ Checking Account
- ☐ Savings account

(Select one) indicated below and the depository institution named below, hereinafter called **DEPOSITORY,** to credit and/or debit the same to such account.

DEPOSITORY (BANK) NAME	**BRANCH #/NAME**
CITY/LOCATION OF BANK	**STATE/ZIP CODE**
TRANSIT/ABA NUMBER	**ACCOUNT NUMBER**

This authority is to remain in full force and effect until **COMPANY** has received written notification from me (or either of us) of its termination in such time and in such manner as to afford **COMPANY** and **DEPOSITORY** a reasonable opportunity to act on it.

PROVIDER NAME (please print)	**Last Four Digits Of Social Security Number/Tax ID XXX-XX-__ __ __ __**
PHONE	[redacted]
PROVIDER'S ADDRESS	**CITY/ZIP CODE**
SIGNATURE	**DATE**

ATTENTION: PLEASE REMEMBER TO ATTACH A VOIDED CHECK

Only for office use

Date Received:	Date Entered:	Initial Verified Address & Provider Number: