Child Development Associates Nutrition Program
180 Otay Lakes Road, Suite 300 * Bonita, CA 91902 * (619) 427-4922

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: Susana Zepeda

AGREEMENT:

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	CDA Provider #

For Office Use Only

Information Verified By:	Date:

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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**
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**
Signature	**Date**

- ***ATTENTION: PLEASE REMEMBER TO ATTACH A VOIDED CHECK***

For Office Use Only

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