COMMUNITY CHILD CARE COUNCIL OF SONOMA COUNTY, INC.

131-A STONY CIRCLE, SUITE 300 SANTA ROSA CA 95401 TEL (707) 544-3077 FAX (707) 544-2625
CHILD CARE REFERRALS (707) 544-3084 CHILD CARE FOOD PROGRAM (707) 522-1412

CACFP Direct Deposit Authorization Form

Provider Information

_____
Print Name as it appears on Bank Account

Type of Request: (select one) ☐ New Request ☐ Change ☐ Cancel

Bank Account Information

Type of Account: (check one) ☐ Checking—Must attach voided check
☐ Savings—Must attach voided deposit slip

Bank Name:_____

Branch Address:_____

Account Number: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Bank Routing/Transit Number: ___ ___ ___ ___ ___ ___ ___ ___ ___

Disclosures

- 4Cs will send a broadcast message through Minute Menu to notify you that funds have been deposited to your account and checks have been mailed.
- It is your responsibility to check your Minute Menu messages, to access the Minute Menu check payment information, and to contact 4Cs immediately if you discover an error.
- You must give two weeks' advance notice if you change banks, close or change account numbers linked with direct deposit and the effective date.
- If an overpayment is made, you will be contacted immediately upon discovery of the error—before any action is taken. Under no circumstance will 4Cs reverse an overpayment to your account without prior notice.
- Direct deposits and 4Cs are bound by the regulations of the National Automated Clearing House Association (NACHA). For information on NACHA visit www.nacha.org

By signing below, I agree and I understand the rules regulating my direct deposit request. I authorize direct deposit of the 4Cs payments into the account identified above. I agree and I understand that if I start and then stop or terminate services and begin services at any time, I will remain on direct deposit using the current account on file. I agree to continue using the current account of file until I have provided 4Cs with a 30-day endorsed Direct Deposit Authorization Form requesting any type of change.

_____
Printed Name of Provider

_____
Provider Signature and Date