

**Delaware Parents Association Inc.**

**101 W. Loockerman St., Dover, De 19904**

**CACFP Direct Deposit**

Provider Name (Please Print) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Number \_\_\_\_\_

Name on Account: \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

Routing Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

Type of Account: \_\_\_\_\_

I understand that the information submitted on this form will be used for the sole purpose of the transfer/payment of funds to the account listed above. Any information obtained will be kept confidential. Should the account information change it is your responsibility to notify this office in writing before payments are made to the account listed above. If you would like to discontinue this service you must submit the request in writing no later than the 20<sup>th</sup> of the month you wish to discontinue this service. I understand these conditions and agree to the terms stated.

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

