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 20th of the month you wish to discontinue this service. I understand these conditions and agree to the terms stated.

Provider Name: ____

Provider Signature: _______________________________________Date: _________________