



INFORMED CONSENT AUTHORIZATION FOR EMPLOYMENT PURPOSES

I hereby give New Wave Home Health Care, LLC, the right to make a thorough investigation of my past employment, education, and activities. I release from all liability, New Wave Home Health Care, LLC, and/or its agents to retrieve information from any/all government agencies, social services agencies and law enforcement agencies, to supply any and all information concerning my background, and release the same from any liability resulting in providing such information. New Wave Home Health Care, LLC does not run credit reports, but is required to conduct criminal conviction searches during the hiring process. I understand that I am required to pass a criminal background check by the Department of Human Services and understand that if for any reason I would be disqualified, New Wave Home Health Care, LLC cannot proceed with my employment.

I understand if my application for employment is granted, New Wave Home Health Care, LLC may obtain further information through subsequent investigations by a consumer reporting agency so as to evaluate me in regard to promotion, reassignment, retention, and to comply with operating license and/or annual criminal conviction searches, as well as investigations resulting from possible employee misconduct, negligence, and/or incidents/accidents involving my employment and/or New Wave Home Health Care, LLC's clients, "consumers", agents, or assigns. This document is valid throughout the course of my employment. I understand that the disclosure of a criminal record will not automatically disqualify me from employment consideration and that my case will be judged on its merits. However, I understand that any false answers or statements or implications made by me in any application or other required documents, or acts of willful misconduct pertaining to my employment shall be considered sufficient cause for denial or employment discharge. In order to verify my identity for purpose of background investigation and for obtaining certain consumer reports (i.e. criminal conviction record), I am voluntarily releasing my date of birth and fully understand that is not a consideration of employment. I hereby release any individual or institution, including its officers, employees, or related personnel, both individually and collectively, from any and all liability for damages of whatever kind, which may at the time result to me, because of compliance with this authorization and request to release information or any attempt to comply with it. I understand that a consumer and/or investigative consumer report for the purpose of employment may be obtained. By checking the box below, the consumer reporting agency and/or New Wave Home Health Care, LLC will mail me a copy.

MN Residence Only: ☐ I would ☐ would not like a copy of any consumer report regarding me.

Please Print or Type Clearly:

Printed Full Legal Name

Date of Birth

☐ I am willing that a photocopy of this document form be accepted with the same authority as the original.

Signature

Date

Phone Number

APPLICANT INFORMATION				
LAST NAME		FIRST NAME		MIDDLE NAME
SSN		DATE OF BIRTH		
MAILING ADDRESS				
PHONE 1		PHONE 2	EMAIL ADDRESS	
Are you a U.S. citizen? Y or N			Authorized to work in the U.S.? Y or N	
Ever been convicted of a crime? Y or N			If yes, please explain.	

AVAILABILITY		
How did you learn of the position available?		
EMPLOYMENT TYPE DESIRED	DESIRED SCHEDULE	AVAILABLE START DATE
Full Time / Part Time / Temp		

EDUCATION			
SCHOOL NAME	LOCATION	YEARS ATTENDED	MAJOR & DEGREE EARNED

REFERENCES			
NAME	COMPANY & POSITION	RELATIONSHIP	PHONE

EMPLOYMENT HISTORY			
EMPLOYER NAME	POSITION HELD	START DATE	END DATE
MAILING ADDRESS			
SUPERVISOR NAME	PHONE	EMAIL ADDRESS	
STARTING RATE OF PAY	ENDING RATE OF PAY	MAY WE CONTACT? Y or N	REASON FOR LEAVING
EMPLOYER NAME	POSITION HELD	START DATE	END DATE
MAILING ADDRESS			
SUPERVISOR NAME	PHONE	EMAIL ADDRESS	
STARTING RATE OF PAY,	ENDING RATE OF PAY	MAY WE CONTACT? Y or N	REASON FOR LEAVING

EMERGENCY CONTACT			
NAME	PHONE NUMBER	EMAIL	RELATIONSHIP

SIGNATURE		
I certify that my answers are true and complete to the best of my knowledge. If this application leads to employment, I understand that false or misleading information in my application or interview may result in my release.		
PRINTED NAME	SIGNATURE	DATE

PERSONAL CARE ASSISTANT (PCA)

Position Purpose:

The Personal Care Assistant performs personal care services to clients unable to live independently in the community -without assistance. The Personal Care Assistant is a position created to serve the clients in the Minnesota Medicaid Personal Care Assistant Program. Clients must be in a stable medical condition and be able to direct their own care. The Personal Care Assistant works within the guidelines of a plan of care established by the client, physician, and supervising Qualified Professional (QP). The PCA reports directly to the Nursing Supervisor.

Qualifications: Professional and Personal:

Be eighteen (18) years of age or have been approved to work by the employer and met state guidelines for persons between the age of 16-18 years

- Have demonstrated ability to work with little direct supervision judgments.
- Have demonstrated dependability, tact, and ability to follow orders.
- Possess good interpersonal communication skills.
- Possess and maintain good physical and mental health, including current TB testing (refer To Health Screening policy).
- Have US Citizenship or evidence of alien work permit.
- Pass background study in State of MN
- Must not have jeopardized health and welfare of vulnerable adults through physical abuse, sexual abuse, or neglect as defined in Minnesota Statutes Section 626.557.
- Must not misuse or show dependency on mood altering chemicals including alcohol.

Must have completed one or more of the following:

A Nursing Assistant training program or its equivalent, for which competency as a Nursing Assistant is determined according to a test administered by State Board of Vocational Technical Education OR

- A Home Health Aide-PCA training program using a curriculum recommended by Minnesota Department of Health OR
- An accredited educational program for registered nurses or licensed practical nurses OR
- A training program that provides the assistant with skills required to perform personal care assistant services specified by New Wave Home Health Care, LLC OR
- Determination by the supervising QP that the assistant has the skills required, through training and experience, to perform the personal care services specified under Covered Services in Medical Assistance Manual.

Specific Functions/Responsibilities:

- Provide bowel and bladder care.
- Perform skin care, including prophylactic routine and palliative measures documented in plan of care.
- Assist with range of motion exercises.
- Provide respiratory assistance.
- Perform transfers.
- Assist with bathing, grooming, hair washing necessary for personal hygiene.
- Perform turning and positioning.
- Assist with medications (normally self-administered).
- Apply and maintain prosthetics and orthotics.
- Clean equipment.
- Assist with dressing/undressing.
- Provide assistance with food, nutrition and diet activities.
- Accompany client to obtain medical diagnoses or treatment.
- Provide services necessary to maintain client's personal health and safety.
- Assist client to complete daily living skills such as personal/oral hygiene.
- Assist with incidental household services.
- Complete the appropriate records to document cares given and pertinent observations.
- Respond and attend to client requests promptly.
- Maintain proper hand washing techniques.
- Maintain a safe client environment.
- Maintain client confidentiality; treat clients and families with respect.
- Understand, accept, and respond to the emotional needs of each client.

- Participate in training programs to meet compliance requirements.
- Accept and fulfill assignments with New Wave Home Health Care, LLC; exercise judgment in accepting assignments.
- Perform other related duties and responsibilities as deemed necessary.

Personal Care Assistant May Not:

- Provide services except as employee of an enrolled provider company.
- Provide services not outlined in the plan of personal care services.
- Provide services that are not supervised by a Registered Nurse or Qualified Professional.
- Provide personal care services to clients for whom they are legal guardians or responsible party.
- Perform sterile procedures.
- Give injections of fluids into veins, muscles, or skin.
- Provide services in an adult or child foster home without prior approval from the Department of Human Services.

Physical/Environmental Demands:

See ADA Requirements

I have read and understand the above job description of the Personal Care Assistant.

Signed _____

Date: _____

Employee's Withholding Certificate

OMB No. 1545-0074

Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay.

Give Form W-4 to your employer.

Your withholding is subject to review by the IRS.

2025

Step 1: Enter Personal Information	(a) First name and middle initial	Last name	(b) Social security number
	Address		Does your name match the name on your social security card? If not, to ensure you get credit for your earnings, contact SSA at 800-772-1213 or go to www.ssa.gov .
	City or town, state, and ZIP code		
	(c) <input type="checkbox"/> Single or Married filing separately <input type="checkbox"/> Married filing jointly or Qualifying surviving spouse <input type="checkbox"/> Head of household (Check only if you're unmarried and pay more than half the costs of keeping up a home for yourself and a qualifying individual.)		

TIP: Consider using the estimator at www.irs.gov/W4App to determine the most accurate withholding for the rest of the year if: you are completing this form after the beginning of the year; expect to work only part of the year; or have changes during the year in your marital status, number of jobs for you (and/or your spouse if married filing jointly), dependents, other income (not from jobs), deductions, or credits. Have your most recent pay stub(s) from this year available when using the estimator. At the beginning of next year, use the estimator again to recheck your withholding.

Complete Steps 2–4 ONLY if they apply to you; otherwise, skip to Step 5. See page 2 for more information on each step, who can claim exemption from withholding, and when to use the estimator at www.irs.gov/W4App.

Step 2: Multiple Jobs or Spouse Works	Complete this step if you (1) hold more than one job at a time, or (2) are married filing jointly and your spouse also works. The correct amount of withholding depends on income earned from all of these jobs. Do only one of the following. (a) Use the estimator at www.irs.gov/W4App for the most accurate withholding for this step (and Steps 3–4). If you or your spouse have self-employment income, use this option; or (b) Use the Multiple Jobs Worksheet on page 3 and enter the result in Step 4(c) below; or (c) If there are only two jobs total, you may check this box. Do the same on Form W-4 for the other job. This option is generally more accurate than (b) if pay at the lower paying job is more than half of the pay at the higher paying job. Otherwise, (b) is more accurate <input type="checkbox"/>
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Complete Steps 3–4(b) on Form W-4 for only ONE of these jobs. Leave those steps blank for the other jobs. (Your withholding will be most accurate if you complete Steps 3–4(b) on the Form W-4 for the highest paying job.)

Step 3: Claim Dependent and Other Credits	If your total income will be \$200,000 or less (\$400,000 or less if married filing jointly): Multiply the number of qualifying children under age 17 by \$2,000 \$ _____ Multiply the number of other dependents by \$500 \$ _____ Add the amounts above for qualifying children and other dependents. You may add to this the amount of any other credits. Enter the total here	3	\$
Step 4 (optional): Other Adjustments	(a) Other income (not from jobs). If you want tax withheld for other income you expect this year that won't have withholding, enter the amount of other income here. This may include interest, dividends, and retirement income	4(a)	\$
	(b) Deductions. If you expect to claim deductions other than the standard deduction and want to reduce your withholding, use the Deductions Worksheet on page 3 and enter the result here	4(b)	\$
	(c) Extra withholding. Enter any additional tax you want withheld each pay period . .	4(c)	\$

Step 5: Sign Here	Under penalties of perjury, I declare that this certificate, to the best of my knowledge and belief, is true, correct, and complete.		
	Employee's signature (This form is not valid unless you sign it.)		Date
Employers Only	Employer's name and address	First date of employment	Employer identification number (EIN)



Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS

Form I-9

OMB No.1615-0047

Expires 05/31/2027

START HERE: Employers must ensure the form instructions are available to employees when completing this form. Employers are liable for failing to comply with the requirements for completing this form. See below and the [Instructions](#).

ANTI-DISCRIMINATION NOTICE: All employees can choose which acceptable documentation to present for Form I-9. Employers cannot ask employees for documentation to verify information in **Section 1**, or specify which acceptable documentation employees must present for **Section 2** or Supplement B, Reverification and Rehire. Treating employees differently based on their citizenship, immigration status, or national origin may be illegal.

Section 1. Employee Information and Attestation: Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.

Last Name (Family Name)		First Name (Given Name)		Middle Initial (if any)	Other Last Names Used (if any)		
Address (Street Number and Name)			Apt. Number (if any)	City or Town		State	ZIP Code
Date of Birth (mm/dd/yyyy)	U.S. Social Security Number		Employee's Email Address			Employee's Telephone Number	
I am aware that federal law provides for imprisonment and/or fines for false statements, or the use of false documents, in connection with the completion of this form. I attest, under penalty of perjury, that this information, including my selection of the box attesting to my citizenship or immigration status, is true and correct.		Check one of the following boxes to attest to your citizenship or immigration status (See page 2 and 3 of the instructions.):					
		<input type="checkbox"/> 1. A citizen of the United States					
		<input type="checkbox"/> 2. A noncitizen national of the United States (See Instructions.)					
		<input type="checkbox"/> 3. A lawful permanent resident (Enter USCIS or A-Number.)					
		<input type="checkbox"/> 4. An alien authorized to work until (exp. date, if any)					
		If you check Item Number 4., enter one of these:					
		USCIS A-Number	OR	Form I-94 Admission Number	OR	Foreign Passport Number and Country of Issuance	
Signature of Employee					Today's Date (mm/dd/yyyy)		

If a preparer and/or translator assisted you in completing Section 1, that person **MUST** complete the [Preparer and/or Translator Certification](#) on Page 3.

Section 2. Employer Review and Verification: Employers or their authorized representative must complete and sign Section 2 within three business days after the employee's first day of employment, and must physically examine, or examine consistent with an alternative procedure authorized by the Secretary of DHS, documentation from List A OR a combination of documentation from List B and List C. Enter any additional documentation in the Additional Information box; see Instructions.

List A		OR	List B	AND	List C	
Document Title 1						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 2 (if any)		Additional Information				
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
Document Title 3 (if any)						
Issuing Authority						
Document Number (if any)						
Expiration Date (if any)						
		<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.				
Certification: I attest, under penalty of perjury, that (1) I have examined the documentation presented by the above-named employee, (2) the above-listed documentation appears to be genuine and to relate to the employee named, and (3) to the best of my knowledge, the employee is authorized to work in the United States.					First Day of Employment (mm/dd/yyyy):	
Last Name, First Name and Title of Employer or Authorized Representative			Signature of Employer or Authorized Representative		Today's Date (mm/dd/yyyy)	
Employer's Business or Organization Name			Employer's Business or Organization Address, City or Town, State, ZIP Code			

For reverification or rehire, complete [Supplement B, Reverification and Rehire](#) on Page 4.

LISTS OF ACCEPTABLE DOCUMENTS

All documents containing an expiration date must be unexpired.

* Documents extended by the issuing authority are considered unexpired.

Employees may present one selection from List A or a combination of one selection from List B and one selection from List C.

Examples of many of these documents appear in the Handbook for Employers (M-274).

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND LIST C Documents that Establish Employment Authorization
<ol style="list-style-type: none"> 1. U.S. Passport or U.S. Passport Card 2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551) 3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa 4. Employment Authorization Document that contains a photograph (Form I-766) 5. For an individual temporarily authorized to work for a specific employer because of his or her status or parole: <ol style="list-style-type: none"> a. Foreign passport; and b. Form I-94 or Form I-94A that has the following: <ol style="list-style-type: none"> (1) The same name as the passport; and (2) An endorsement of the individual's status or parole as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form. 6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI 		<ol style="list-style-type: none"> 1. Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address 2. ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, sex, height, eye color, and address 3. School ID card with a photograph 4. Voter's registration card 5. U.S. Military card or draft record 6. Military dependent's ID card 7. U.S. Coast Guard Merchant Mariner Card 8. Native American tribal document 9. Driver's license issued by a Canadian government authority For persons under age 18 who are unable to present a document listed above: 10. School record or report card 11. Clinic, doctor, or hospital record 12. Day-care or nursery school record 	<ol style="list-style-type: none"> 1. A Social Security Account Number card, unless the card includes one of the following restrictions: <ol style="list-style-type: none"> (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION 2. Certification of report of birth issued by the Department of State (Forms DS-1350, FS-545, FS-240) 3. Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal 4. Native American tribal document 5. U.S. Citizen ID Card (Form I-197) 6. Identification Card for Use of Resident Citizen in the United States (Form I-179) 7. Employment authorization document issued by the Department of Homeland Security <p style="margin-left: 20px;">For examples, see Section 7 and Section 13 of the M-274 on uscis.gov/i-9-central.</p> <p style="margin-left: 20px;">The Form I-766, Employment Authorization Document, is a List A, Item Number 4. document, not a List C document.</p>
Acceptable Receipts May be presented in lieu of a document listed above for a temporary period. For receipt validity dates, see the M-274.			
<ul style="list-style-type: none"> • Receipt for a replacement of a lost, stolen, or damaged List A document. • Form I-94 issued to a lawful permanent resident that contains an I-551 stamp and a photograph of the individual. • Form I-94 with "RE" notation or refugee stamp issued to a refugee. 	OR	Receipt for a replacement of a lost, stolen, or damaged List B document.	Receipt for a replacement of a lost, stolen, or damaged List C document.

*Refer to the Employment Authorization Extensions page on [I-9 Central](#) for more information.



**Supplement A,
Preparer and/or Translator Certification for Section 1**

**Department of Homeland Security
U.S. Citizenship and Immigration Services**

**USCIS
Form I-9
Supplement A**
OMB No. 1615-0047
Expires 05/31/2027

Last Name (<i>Family Name</i>) from Section 1.	First Name (<i>Given Name</i>) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement must be completed by any preparer and/or translator who assists an employee in completing Section 1 of Form I-9. The preparer and/or translator must enter the employee's name in the spaces provided above. Each preparer or translator must complete, sign, and date a separate certification area. Employers must retain completed supplement sheets with the employee's completed Form I-9.

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial (<i>if any</i>)	
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial (<i>if any</i>)	
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial (<i>if any</i>)	
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator		Date (<i>mm/dd/yyyy</i>)	
Last Name (<i>Family Name</i>)	First Name (<i>Given Name</i>)	Middle Initial (<i>if any</i>)	
Address (<i>Street Number and Name</i>)	City or Town	State	ZIP Code



Supplement B,
Reverification and Rehire (formerly Section 3)

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
Supplement B
OMB No. 1615-0047
Expires 05/31/2027

Last Name (Family Name) from Section 1.	First Name (Given Name) from Section 1.	Middle initial (if any) from Section 1.
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Instructions: This supplement replaces Section 3 on the previous version of Form I-9. Only use this page if your employee requires reverification, is rehired within three years of the date the original Form I-9 was completed, or provides proof of a legal name change. Enter the employee's name in the fields above. Use a new section for each reverification or rehire. Review the Form I-9 instructions before completing this page. Keep this page as part of the employee's Form I-9 record. Additional guidance can be found in the Handbook for Employers: Guidance for Completing Form I-9 (M-274)

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Date of Rehire (if applicable)		New Name (if applicable)	
Date (mm/dd/yyyy)	Last Name (Family Name)	First Name (Given Name)	Middle Initial
Reverification: If the employee requires reverification, your employee can choose to present any acceptable List A or List C documentation to show continued employment authorization. Enter the document information in the spaces below.			
Document Title	Document Number (if any)	Expiration Date (if any) (mm/dd/yyyy)	
I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented documentation, the documentation I examined appears to be genuine and to relate to the individual who presented it.			
Name of Employer or Authorized Representative	Signature of Employer or Authorized Representative	Today's Date (mm/dd/yyyy)	
Additional Information (Initial and date each notation.)			<input type="checkbox"/> Check here if you used an alternative procedure authorized by DHS to examine documents.

Employee Direct Deposit Banking Authorization Form

RUN Powered by ADP®



This form can be filled out online and printed.*
Please complete all fields.

Company Information

Company Name: New Wave Home Health Care

Date: _____

Employee Information/Authorization

Important! Please read and sign before completing and submitting.

I hereby voluntarily authorize the Company named above (hereafter "Employer"), either directly or through its payroll service provider, to deposit any amounts owed me, by initiating credit entries to my account (s) at the financial institution (s) of my choice (hereinafter "Bank") indicated on this form. Further, I authorize Bank to accept and to credit any credit entries indicated by Employer, either directly or through its payroll service provider, to my account. To the extent permitted by law, in the event that Employer or its payroll service provider deposits funds erroneously into my account (s), I authorize Employer, either directly or through its payroll service provider, to debit my account for an amount not to exceed the original amount of the erroneous credit.

To the extent permitted by law, I understand that I have the right to refuse consent or revoke authorization of direct deposit at any time without fear of retaliation, and I have the right to receive any payment owed to me by other means. This authorization is to remain in full force and effect until Employer and Bank have received written notice from me of its termination in such time and manner as to afford Employer and Bank reasonable opportunity to act on it.

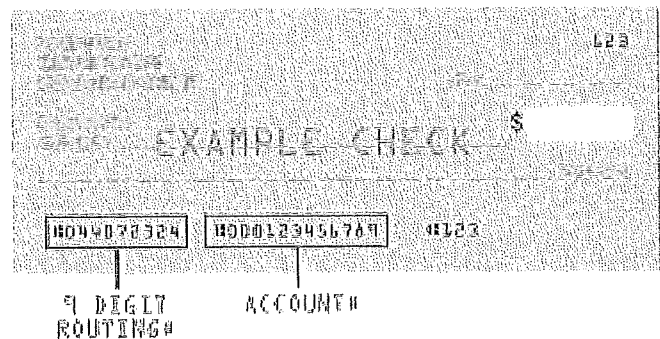
Legal Name: _____
(Last Name, First Name, Middle Initial)

Signature: _____ Date: _____

Deposit/Account Information

For a checking account, attach a voided check, not a deposit slip. If you don't have a check, ask your bank to give you the Routing Number (the nine-digit American Bankers Association (ABA) number that identifies both the Company's bank and the Federal Reserve Bank) for your account.

Note: If you have a paycard, set it up as a checking account, not a savings account. Contact the paycard issuer for the account number/routing number information.



Employee Direct Deposit Banking Authorization Form

RUN Powered by ADP®

1. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:

☐ Checking ☐ Savings

Amount to deposit in selected account:

\$ _____ or ☐ Full Net Amount

2. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:

☐ Checking ☐ Savings

Amount to deposit in selected account:

\$ _____ or ☐ Full Net Amount

3. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:

☐ Checking ☐ Savings

Amount to deposit in selected account:

\$ _____ or ☐ Full Net Amount

4. Deposit/Account Information

Bank Name: _____

Routing #: _____ Account #: _____

Choose only one account type:

☐ Checking ☐ Savings

Amount to deposit in selected account:

\$ _____ or ☐ Full Net Amount

Take advantage of Employee Access® in RUN Powered by ADP® to let your employees manage their own direct deposits.

***Attention Payroll Contact:** Employers must keep each original Employee Direct Deposit Banking Authorization form on file as long as the employee is using direct deposit, and for two years thereafter. Employers may be subject to certain federal and state direct deposit notice, authorization and record retention requirements. Please review your applicable federal, state and local laws. This form is provided for convenience only and is not meant and should not be construed as legal, HR, financial, insurance, tax or accounting advice. You should consult with your own legal counsel, human resource, accounting or other professional advisor for circumstances pertaining to your business.