



Payroll Services Employee Information Form

Attach a Voided Personal Check (not deposit slip) here if you select Direct Deposit

I. Employee Information

Email Address _____ SSN: _____

Last Name _____ First Name _____ Middle _____

Date of Birth Month _____ Day _____ Year _____ Gender: Male _____ Female _____

Ethnicity and Race

Are you Hispanic or Latino (a person of Cuban, Mexican, Puerto Rican, South Central American, or other Spanish culture or origin, regardless of race)? Yes _____ No _____

Please select the racial category or categories with which you most closely identify. Check as many as apply.

(1) _____ American Indian or Alaska Native (2) _____ Asian (3) _____ Black or African American
(4) _____ Native Hawaiian or Other Pacific Islander (5) _____ White

II. Payroll Check Distribution (Please Mark Only One Box)

☐ Direct Deposit ☐ Mail ☐ Pick Up Check at Payroll Services

III. NACHA Requirements for ACH Transactions

An employee that selects "Direct Deposit" must also make the appropriate selection for The National Automated clearing House Association (NACHA). NACHA adopted specific rules regarding International ACH Transactions (IAT) which require entities that originate ACH (Direct Deposit) payments to comply by requiring all payees to identify the intended final destination of payments issued through the ACH network. (For further information on these rules, please contact your financial institution.)

Check appropriate selection

_____ No portion of payments will be forwarded from my U.S. bank account to a bank or financial agency outside the United States.
_____ Only a portion of payments will be forwarded from my U.S. bank account to a bank or financial agency outside the United States.
_____ 100% of payments will be forwarded from my U.S. bank account to a bank or financial agency outside the United States. Specify the name of the country where 100% of payments will be forwarded. _____ (Required)

**payments from Atlas Care Connect will be issued by check instead of direct deposit.

IV. Direct Deposit of Checks (Authorization Agreement for Direct Deposit)

I hereby authorize Vastland Health Services to initiate credit and, if necessary, debit adjustments for any credit entries in error to my account indicated below and the depository named below to credit and/or debits the same to such account. I also attest to the accuracy of the intended final destination of payments issued through the ACH network. I further understand that Vastland Health Services will comply at all times with the National Automated Clearing House Association's rules. This authorization is to remain in full force and effect until the Vastland Health Services has received notification from me of its termination in such time and such manner as to afford Vastland Health Services and DEPOSITORY a reasonable opportunity to act on it.

Bank Name _____ Type of Account () Checking OR () Savings

Routing Number _____ Account Number _____

* The routing number is usually the first nine digits on the lower left-hand corner of your personal check; however, if deposit is to a credit union or an investment account, contact your financial institution for proper ACH routing instructions.



REQUIRED: Signature_____ Date _____