

Instructions: Please fill out the information, as applicable, then select the appropriate box below. After entering the Financial Institution information, please attach the required documentation as listed. Review the authorization to Set-Up then sign and date. Please submit the completed form to PAS via one of the following options:

Mail or Drop-Off

20500 Eureka Rd, Suite 112
Taylor, MI 48180

Email

PASOnboarding@PASSelfDirection.com

Fax

734.290.9702

SECTION 1: PARTICIPANT

Participant Full Name: _____

SECTION 2: DIRECT CARE WORKER / VENDOR INFORMATION

Direct Care Worker Full Name: _____

Vendor Full Name: _____

Last Four (4) Digits of Direct Care Worker SSN OR Vendor EIN: _____ Effective Date: _____

Participant Program: _____

CHECK ONE BOX ONLY:

New DD Set-Up

New Paycard Set-Up

SECTION 3: FINANCIAL INSTITUTION INFORMATION

Name of Financial Institution: _____

Type of Account Checking Savings Percentage: _____%

FOR CHECKING ACCOUNT: Tape a voided check here
(No starter check or deposit slip)

FOR SAVINGS ACCOUNT: Attache a letter from bank
with routing and account numbers
(Letter must be typed on bank's letterhead).

(continued on next page)

IF THERE IS A SECOND FINANCIAL INSTITUTION:

Name of Financial Institution: _____

Type of Account Checking Savings Percentage: _____%



FOR CHECKING ACCOUNT: Tape a voided check here
(No starter check or deposit slip)

FOR SAVINGS ACCOUNT: Attache a letter from bank
with routing and account numbers
(Letter must be typed on bank's letterhead).



SECTION 4: AUTHORIZATION FOR SET-UP

I hereby authorize PAS (Personal Accounting Services, LLC) to **deposit** any amount owed to me for wages and/or reimbursements. PAS is not responsible for any erroneous information provided. Also, I grant PAS permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. This authorization is to remain in full force and effect until PAS receives written notification from me to terminate the agreement.

I hereby elect and consent to receive my wages to a **paycard** by electronic transfer. I also grant PAS (Personal Accounting Services, LLC) permission to correct and/or adjust any electronic funds transfer resulting from an erroneous overpayment by debiting my account. I acknowledge I have received a copy of the terms, conditions, and fees associated with using the aforementioned paycard. This authorization is to remain in full force and effect until PAS receives written notification from me to terminate the agreement.

Direct Care Worker Signature: _____ Date: _____

Paycard Number:
For office use only.