90-300 APPENDIX D. FORM 16-66 HHSA

County of San Diego — Department of Social Services

Direct Deposit Sign-Up Form

Case Name: _____

Case Number: _____ FBU: _____

ET Number: _____

Follow these instructions to convert your case to direct deposit. Please print and fill this form out completely.

INSTRUCTIONS:

1. Client must complete Section 1, and
2. Either:
   a. ask financial institution to complete Section 2, or
   b. write "VOID" across the front of a personal check and attach it to this form.
3. Client must return this form to his or her Eligibility Technician.

Section 1 (To be completed by the Payee)

Name of Payee (last, first, middle)	
Case name if different than payee:	Type of account: *(circle one)* Checking Savings
Address:	Payee's Social Security Number:
City, State and Zip Code	Telephone number:

Payee Certification: By signing this form, I am authorizing the Department of Social Services to directly deposit any cash benefits I am enti-tled to directly into my designated account. Should cash benefits be terminated for any reason, and child support payments are collected on behalf by the Office of the District Attorney, I further authorize direct deposit of those payments by the District Attorney into my designated account. I certify that I have read this form and I fully understand my responsibility to report changes in my household, income property. I understand that I must immediately notify my worker if I am removed from the account or it is closed for any reason. The Department of Social Services is not responsible for how money is disbursed after it is deposited.

Signature: _____ Date: _____
Payee

Signature: _____ Date: _____
Joint payee (if applicable)

Section 2 (To be completed by Financial Institution or Payee must attach a voided check)

Name and address of financial institution	Depositor account title: (list all account holders)
	Social Security Number:
Routing number ☐☐☐☐—☐☐☐☐ Check digit ☐	Account number:

Financial Institution Certification

I confirm the identity of the above-named payee(s) and the account number and title. As representative of the above-named financial institution, I certify that the financial institution agrees to receive and deposit payment from the Department of Social Services.

Representative's name (print)	Signature of Representative	Telephone number	Date

Eligibility Technician approval: _____
Signature Worker number Date

Distribution: white – Fiscal yellow – case file pink – client