Innovative HealthCare Employee Profile Form

Company Name:

Location (if applicable): Department (if applicable):

Full Time:

First Name: M: Last:

Social Security Number Hire Date:

Mailing Address:

City: State: Zip: County of Residence:

Email:

Date of Birth: Employee Phone Number:

Federal Filing Status (Mark one): Married ☐ Single ☐ Head of Household ☐

Other Dependents ☐ Other Income ☐

Deductions: Additional Withholdings:

Deductions ☐ Additional Withholdings ☐

State Filing Status (Mark one): Married ☐ Single ☐ Not Applicable ☐

Exemptions ☐ Additional Withholdings ☐

Pay Information (Mark one): Salary ☐ Exempt ☐ Salary Non-Exempt ☐ 1099 ☐

Gross Salary or Hourly Rate (Per pay Period, Not Annually):

Voluntary Deductions	Amount Per Pay Period	Deduction Forms Attach

Phone 1.800.913.1904 Fax 618.993.3305 All changes to payroll must be in writing.

Company Name
Employee Name

I authorize you and the financial institution(s) listed below to deposit my pay automatically to the indicated account(s) and to make adjusting entries as may be required.

Bank/Credit Union	**Type**	**Amount of Percentage**	**Routing Number**	**Account Number**
	Checking/ Savings			
	Checking/ Savings			
	Checking/ Savings			

Please Check One:

	New Or Additional Direct Deposit		
	Change the Bank or Account Number on Existing Direct Deposit:	Account Number to be replaced:	
	Change the Amount of an Existing Direct Deposit	Amount Was:	Amount Changed To:
	Other, Please Explain:		

PLEASE ATTACH A VOIDED CHECK OR BANK LETTER FOR THE DIRECT DEPOSIT BANK ACCOIJNT AS VERIFICATION FOR EACH REQUEST. PAYROLL WILL BE PROCESSED AS A PAPER CHECK UNTIL I HE VERIFICATION IS RECEIVED.

It is my responsibility to verify deposits on a per pay period basis before writing checks against these funds. This Authorization can take up to three pay periods to activate. I understand that "neither" my employer Payroll Services is responsible for bank errors or fees I may cancel this Direct Deposit(s) at any time .

Signature: **Date:**

Dash Paycard ENROLL TODAY EMPLOYEE PACKET

You do not have to accept this payroll card.
Ask your employer about other ways to receive your wages.

Monthly Fee	Per Purchase	ATM withdrawal	Cash reload
$0.00	$0.50*	**$0.00** in-network $3.00 out-of-network	$3.95*

ATM balance inquiry (in-network or out-of-network)	$0.50
Customer service (automated or live agent)	$0.00 per call
Inactivity (after 6 months with no transactions)	$2.95 per month

We charge 7 other types of fees. Here are some of them:

Issue a replacement card for a lost/stolen card	$5.00
Transfer funds to a bank account	$2.00

*This fee can be lower depending on how and where this card is used.

No overdraft/credit feature.
Your funds are eligible for FDIC insurance.

For general information about prepaid accounts, visit cfpb.gov/prepaid.
Find details and conditions for all fees and services in the Payment Card List of All Fees or call 888621-1397 or visit payment-card.com.

YES. I want to receive a Payment card for my Employer to submit payment to my card account. I understand that this card was provided to me as an option by my Employer and that my Employer has provided me a listing of all fees associated with this card that will be deducted from the card balance.

Name

Address

City

Social Security Number Date of Birth

Phone Email

I hereby authorize my Employer to act as my agent to submit my application for the Payment card to the issuing Financial Institution of the Payment card. and to the Terms and Conditions governing my use of Payment Card that I will receive et the time I receive my card. I understand that this authorization replaces any previous authorization relating to my employer's payment to me. and unless terminated by my Employer or issuing financial institution, this authorization will remain in fun force and effect until my Employer has received written notification from me of its termination in such time as to afford it a reasonable opportunity to act. or t have terminated the Payment Card as provided in the Terms and Conditions I received with the card. Upon approval of my application for the Payment Card. I hereby authorize my employer to deposit payments due to me to my Payment Card and perform the following corrective actions related to my payment card: 1. Correct any funding error made by my Emp10Frto which I am not entitled by submitting a correcting debit to my pay card account through ACH or directly to my pay card account; 2. At my request, submit 8 request for a change in my pay card account status to lost or stolen (or effectuate exchange in the employee's account status to lost or stolen): 3. At my request transfer funds to a newly issued card; This Consent does not allow my Employer to access my cardholder activity detail on my Payment Card without my prior consent,

The USA PATRIOT Act is e federal law that requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. You will be asked to provide your name, & valid physical U.S. Street address, B telephone number. e date of birth. and other information that will allow us to identify you. You may also be asked to provide documentation as proof of identification. I acknowledge and agree that this authorization may be rejected or discontinued by the issuing Financial Institution at any time. 3

INNOVATIVE HEALTH CARE CDS

Direct Deposit Policy

Payroll is processed weekly for hundreds of attendants and is processed based on your chosen method of payment (Check card or direct deposit into your personal account). We know that issues arise and direct deposits may need to change or be cancelled for whatever reason. To avoid your payroll going into inaccurate or inactive accounts ANY PAYROLL CHANGES MUST BE SUBMITTED TO OUR OFFICE AT LEAST ONE WEEK PRIOR TO PAYDATE. Pay dates are on the 15th and 30th of every month and any changes need to be submitted or reported on or before the 8th or the 22nd of the month for the appropriate pay period. WE ARE NOT RESPONSIBLE FOR IMMEDIATE REQUEST TO STOP PAYMENT INTO YOUR ACCOUNT.THIS MUST BE HANDLED WITH YOUR BANK. ANYFUNDS ALREADY CREDITED TO YOUR ACCOUNT ARE NOT
OUR RESPOSIBILITY. To make changes please call our office at 314.305-0738 ext. 404

Attendant Signature	Date
Attendant Print	Date
IHC Representative	Date

INNOVATIVE HEALTH CARE CDS

Mandatory EVV (Electronic Visit Verification)

EVV system automatically captures information about the services you receive in your home. This service MUST be used by attendant to log time in/out and work performed for the Consumer. Effective Dec. 1st 2019 INNOVATIVE HEALTH CARE CDS will NO LONGER accept time sheets for services rendered THIS IS PER THE STATE OF MISSOURI.

Failure to allow attendant to utilize EVV system could result in the risk of losing your personal care services.

You will receive a clock in number from our company which allows you to clock in and out from the CLIENTS phone (Please see attached form for instructions)

(Client Initial Box) I have read and understand the information regarding the EVV system

______________________	______________________	__________
Print Consumer Name	Sign Consumer Name	Date
______________________	______________________	__________
Print Attendant Name	Sign Attendant Name	Date

Clock in number assigned

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