



Form of Payment

Please select one form of payment below

- I will **pick-up** my check the day of payday.
- Receive my paycheck by **mail**, at the address listed below.

Address:		
City:	State:	Zip:

- Receive my paycheck through **direct deposit**.

Name:	
Bank:	
SSN:	
Type of Account:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account Number:	
Routing Number:	

I, _____, authorize Thrive Home Care to release my paycheck based on my selection listed above. I understand that if for any reason I decide to change my form of payment, I must inform Thrive Home Care immediately. Also, any changes will reflect on the following payroll schedule.

Signature

Date

To submit this form by mail, email, or fax, please use the information listed below.

www.thrivehomecare.com
14895 E. 14th Street, Suite 130 San Leandro, CA 94578
Tel: (510) 680 – 3000 **Toll Free:** (800) 410 – 8818 **Fax:** (800) 684 – 7280
info@thrivehomecare.com