Area Agency on Aging of Western Arkansas
and Visiting Nurses Agency
"Our heart is in your home."

# Payroll Deduction Form

Employee Name: _____ Employee ID: _____

Total amount to be withheld: $_____

Withheld at a rate of $_____per pay period

Purpose:_____

I authorize Area Agency on Aging, Inc. to withhold the amount listed above from my wages. In the event my employment shall terminate, either voluntarily or involuntarily, before the full repayment of the amount listed above, the company may withhold the remaining amount owed from my final pay, except to the extent prohibited by federal or state minimum wage law.

_____ _____

Signature Date