



6315 Hillside Court, suite B, Columbia MD 21046

P 1-800-642-2227 F 410-312-7261 E info@cccsmd.org

Bi-Weekly Authorization Agreement for Automatic Withdrawal of Funds (ACH)

Name on Bank Account _____

Name of Bank _____

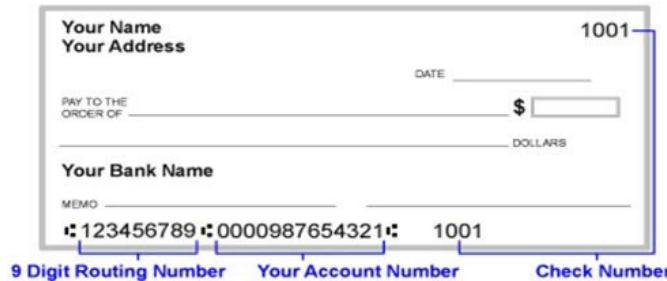
Bank Address _____ City _____ State __ Zip _____

Account Information

Please debit payment directly from my: Checking Account Savings Account

Routing Number _____
(9 digits on the bottom left of your check)

Account Number _____



Payment Information

DMP monthly payment amount \$ _____ Date of first payment _____

Please select **two** ACH Withdrawal dates: 3rd 8th 18th 23rd Other: _____

or

Please select a day of the week to have bi-weekly payments drafted:

___ Monday ___ Tuesday ___ Wednesday ___ Thursday ___ Friday

I/we authorize CCCSMD to electronically debit my/our account. To stop an ACH withdrawal I/we must notify CCCSMD at least five (5) business days prior to the next scheduled withdrawal date.

Client Authorization

Signature _____ Date _____

RETURN THIS FORM WITH A COPY OF A VOIDED CHECK OR A LETTER FROM YOUR BANK CONFIRMING YOUR FULL ACCOUNT NUMBER.

Getting Started with Automatic Withdrawal (ACH)

How to Enroll

1. Complete the Authorization Agreement for Automatic Withdrawal of Funds form.
2. Select your first payment date, which may differ from your recurring monthly ACH debit date.
3. Select your monthly ACH withdrawal date. This date will determine the date your funds are withdrawn from your account each month. Should the withdrawal date fall on a holiday or weekend, the funds will be withdrawn on the next business day.
4. Sign and date the authorization agreement and return the form to CCCSMD by **fax at: 410-312-7261 Attention: Client Services** or by **email at: info@cccsmd.org** *Subject Line: ACH Enrollment Form.*

How to Make ACH Changes

Please contact CCCSMD at 1-800-642-2227 for any permanent or temporary changes that will impact your monthly ACH debit at least two (2) full business days prior to your scheduled monthly withdrawal date.

How to Stop ACH Payments

Please email us at info@cccsmd.org *Subject Line: ACH Stop Request* or call us at 1-800-642-2227 at least five (5) business days prior to your scheduled monthly withdrawal date.

Notice to Clients

The first bi-weekly payment will be held and disbursed as a full payment for new DMP clients. Each payment after that will be disbursed to your creditors in bi-weekly installments.

In the event a creditor requests an increase in your monthly payment amount, CCCSMD will notify you in writing.

******Please Retain This Information for Your Records******