6315 Hillside Court, Suite B, Columbia MD 21046

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

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 (check one): ☐ 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 _____

CHOOSE AN ACH WITHDRAWAL DATE 10 DAYS PRIOR TO YOUR CONSUMER CREDIT COUNSELING SERVICE OF MARYLAND AND DELAWARE, INC. (CCCSMD) DUE DATE:

Please select an ACH Withdrawal date: ☐ 3rd ☐ 8th ☐ 18th ☐ 23rd

I (we) authorize Consumer Credit Counseling Service of Maryland and Delaware Inc. d/b/a CCCSMD to electronically debit my (our) account. In order to change or stop an ACH withdrawal I (we) must notify CCCSMD at least 5 business days prior to the current month's withdrawal date. Funds will be disbursed approximately 3 business days after the withdrawal date. I (we) have attached a voided check or bank document showing the account holders name, routing and account number. I (we) understand that CCCSMD may charge a $15 fee for insufficient funds (NSF) returned to them on my account, except where prohibited by law. **I also understand that if I stop a payment, and funds have already been disbursed to my creditors for that payment, I am required to reimburse CCCSMD the full amount of funds disbursed.**

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 This date will determine the date your funds are withdrawn from your account each month. Should the withdrawal date fall on a holiday or weekend, the funds will be withdrawn on the next business day.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 notify CCCSMD in writing about permanent or temporary changes that will impact your monthly ACH debit at least five (5) 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

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

If CCCSMD receives a non-sufficient funds (NSF) notification on a withdrawal, ***you will be charged $15, unless prohibited by law***. Please be advised that your ACH service may also be suspended and this could result in a requirement of payments via money order or certified check.

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