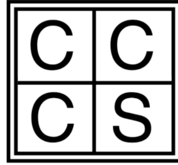

Client Name ______________________________ Client Number ___________________
Daytime Phone Number _____________________ Home Phone Number ___________________
E-Mail Address ____

***I wish to sign up for ACH withdrawal*:**

[Write the word "VOID" on your blank check or savings withdrawal slip and staple it here.]

- Amount of withdrawal: _____________
- Month of First Withdrawal: __________________ **(Required field to process your ACH request)**
- Date of Withdrawal: **1st 5th 10th 15th 20th 25th**
  (Only Choose One Date Please)

Please be aware that your requested withdrawal will be held for three business days after the funds have been withdrawn from your specified bank account and then disbursed to your creditors on CCCS' next scheduled disbursement. Please contact our Customer Service Department at 800-989-2227 if you require assistance in choosing the best withdrawal date to meet your needs.

I wish to make the following change(s):

All changes to ACH require a $5.00 fee that will be withdrawn from your next scheduled withdrawal. A minimum of 5-business days notice is required in writing to process your request. This request can be submitting via e-mail achrequest@cccsdv.org or fax 215-563-7020.

Please select your request.

Change Amount: From ___________ To ____________ Effective ___________

Change Draft Date *Select one of the following withdrawal dates.*

1st 5th 10th 15th 20th 25th

ACH funds are not guaranteed funds; therefore, may not disburse to your creditors for up to 5 business days.

Change Bank Account Information

A BLANK VOIDED CHECK MUST BE ATTACHED

If your financial institution does not provide savings slips or checks, please attach a letterhead letter from your bank indicating your routing and account number for auto withdrawal.

[Write the word "VOID" on your blank check or savings withdrawal slip and staple it here.]

Terminate my Auto Draft effective: _______________________

Change regular draft amount one time only to $ _______________ in the month of _______________ and return to regular withdrawal amount of $ ___________ on the month of _______________ .

I authorize CCCS of Delaware Valley to process debit entries from my account. This authority will remain in effect until I give reasonable notification to terminate this authorization. I understand there will be a 15.00 fee automatically charged to my account for any insufficient funds (NSF) transactions. I understand that CCCS may need to increase my monthly scheduled payments due to possible increases in my proposed payments to creditors. If the increase in my payment is $20.00 or less, CCCS will use my original authorization to debit my account and will notify me of any increases.

Signature __________________________________ Date _________________________

Please return this form to CCCS of Delaware Valley, Attention ACH, 1515 Market Street, Suite 1325, Philadelphia, PA 19102.

Please keep a copy of this form for your records.