United Way
Community Partner

ccs
american credit counseling service, Inc.
A Non-Profit Agency

BSI REGISTERED
ISO 9001 2008
FS 96013

EZ-PAY AUTHORIZATION FORM

Agency Name: American Credit Counseling Service, Inc.

FOR OFFICE USE ONLY: CUSTOMER #_____ DATE_____

Effective date of authorization: ____/____/____

Type of authorization:

- ❑ New authorization
- ❑ Change payment amount
- ❑ Change payment date
- ❑ Change banking information
- ❑ Discontinue electronic payment

Last Name	First Name	
Address		
City	State	Zip
Email Address		

Date of first payment: ____/____/____

If 2X Monthly Date of 2nd payment ____/____/____

Date of last payment: ____/____/____

Frequency of payment (check one):

- ☐ One Time
- ☐ Weekly
- ☐ Twice Monthly
- ☐ Monthly
- ☐ Bi-Weekly

Amount of recurring payment: $_____

Amount of last payment (optional): $_____

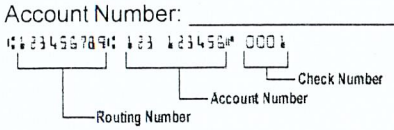
CHECKING / SAVINGS

Please debit payment from my (check one):

- ❑ Savings Account (contact your financial institution for Routing #)
- ❑ Checking Account (staple a voided check below)

Routing Number: _____
Valid Routing # must start with 0, 1, 2, or 3

Account Number: _____



I authorize the above organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

Authorized Signature:_____ Date:_____

If using a checking account, please attach a voided check at the bottom of this page.