

# ACH PARTICIPANT AUTHORIZATION FORM

## AUTHORIZATION AGREEMENT FOR AUTHORIZED WITHDRAWALS (ACH DEBIT)

**Please mail this form to:**

Family Service of Champaign County  
405 S. State Street  
Champaign, IL 61820  
217-352-0099

Monthly  
Donation Amount: \_\_\_\_\_

Beginning  
Month: \_\_\_\_\_

I hereby authorize Family Service of Champaign County to initiate debit entries for monthly donations from my account listed below and allow my depository to debit the same amount to my account. This will initiate on the 15<sup>th</sup> or the first business day thereafter in the beginning month I noted above. These monthly withdrawals will continue on the 15<sup>th</sup> of each month until Family Service receives written notification to discontinue them with reasonable time for both Family Service and the depository to act on the request.

Name \_\_\_\_\_ Signature \_\_\_\_\_

\_\_\_\_\_  
(please print)

Date \_\_\_\_\_ PHONE NO. \_\_\_\_\_

DEPOSITORY  
NAME \_\_\_\_\_ BRANCH \_\_\_\_\_

\_\_\_\_\_  
CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

\_\_\_\_\_  
ROUTING NO. \_\_\_\_\_ ACCOUNT NO. \_\_\_\_\_

DEPOSITORY ACCOUNT TYPE (check one): CHECKING \_\_\_\_\_ SAVINGS \_\_\_\_\_

\_\_\_\_\_

Please include an unused and voided personal check from DEPOSITORY as verification of your account with this completed form and mail to Family Service at the above address. Thank you.