Charities Pooled Trust Inc

Credit Card Authorization Form

Name on Card _____

Card #_____

Expiration ___/____ CCV_____ Zip Code_____

Please note a 2.75% fee will be added to your monthly charge when using a credit/debit card.

Direct Debit (ACH) Authorization Form

☒ **NEW REQUEST**

☐ **CHANGE REQUEST**
- ☐ AMOUNT
- ☐ DATE
- ☐ BANK ACCOUNT

Name _____

Account # _____

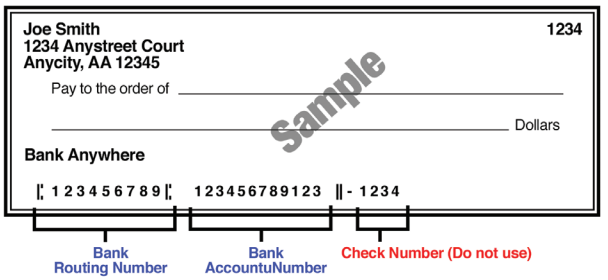
Bank Name _____

Routing # (9 Digits) ____ ____ ____-____ ____ ____-____ ____ ____

Bank Account # _____

☒ Checking ☐ Savings

☐ *Account number is the same as previous ACH form.*



Debit Amount: $_____ ☐ Monthly ☐ **Note**: This amount may change as Medicaid's spend-down amount changes

Date to Start Debits: 3rd, 15th, 22nd, 28th

Monthly Fee: _____ Cancellation/Account Closure Fee $99

☐ Debit One Time Enrollment Fee of $___99_____

By signing this form I authorize Charities Pooled Trust Inc to debit the amount stated on or around the date I indicated each month or immediately for a one time debit. I understand that it could take up to 3 days for the ACH to fully process and that I will have access to the funds only after the funds have fully cleared. I also agree to pay any fee that might result in a returned ACH. This authorization is to remain in full force and effect until written notification from me of its termination in such time and manner to afford CPT a reasonable amount of time to act on it. The cancellation fee within the 1st year is to cover for costs incurred to process and maintain the trust and all efforts to enforce the trust with Medicaid. **Debits from your checking account generally takes 3 business days before they are deposited to us.**

SIGNATURE OF BANK ACCOUNT HOLDER _____Date _____

ATTACH VOIDED CHECK HERE

Please Email, Fax, or Mail this completed form to the Charities Pooled Trust office.

Email: admin@charitiespt.org Fax: 716-313-1239 Mailing Address: PO Box 3146, Buffalo, NY 14240