



## ACH Debit Authorization Agreement

### DEBIT ACCOUNT INFORMATION

Name (as I wish to be listed in any print or electronic publications, may include spouse):

Home Address (Street, City, State & Zip): \_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank Address: (Street, City, State & Zip): \_\_\_\_\_

Bank Routing Number (between symbols I: I: on bottom left corner of check): \_\_\_\_\_

Account Number: \_\_\_\_\_  Checking  Savings

**Per pay period, I would like to support at** (please check one):

\$2 (\$52/year)     \$3.85 (\$100/year)     \$5 (\$130/year)     \$10 (\$260/year)

\$20 (\$520/year)     \$38.50 (\$1000/year)     Other \$ \_\_\_\_\_ (per pay period)

**\*\*\*Please attach a voided check or savings deposit slip\*\*\***

### AUTHORIZATION

I, (name) \_\_\_\_\_, authorize Canton-Inwood Area Health Foundation to initiate automatic debit entries to the account at the bank listed above. I authorize the initiation of credit entries, if necessary, to complete adjustments for any duplicate or erroneous entries made in error to the account listed above. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This Authorization Agreement will remain in effect until I notify you in writing to cancel or change it, and in such time, as to afford the financial institution a reasonable opportunity to act on it. By signing this authorization I hereby acknowledge receipt of a copy of this signed Authorization Agreement.

Name (Please Print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Debiting Account Holder

\_\_\_\_\_  
Date

*All gifts are tax deductible to the fullest extent of the law.*



## One-Time Gift

Name (as I wish to be listed in any print or electronic publications, may include spouse): \_\_\_\_\_

Home Address (Street, City, State & Zip): \_\_\_\_\_

\_\_\_\_\_ Cash or Check for \$ \_\_\_\_\_. (Please make checks payable to Canton-Inwood Area Health Foundation.)

\_\_\_\_\_ I would like to use my: \_\_\_\_\_ Visa \_\_\_\_\_ MasterCard \_\_\_\_\_ American Express \_\_\_\_\_ Discover

Please charge \$ \_\_\_\_\_ to my credit card.

Card number \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Security Code: \_\_\_\_\_

Signature: \_\_\_\_\_

\_\_\_\_\_ I would like to make a one-time ACH debit for \$ \_\_\_\_\_.

Bank Name: \_\_\_\_\_

Bank Address: (Street, City, State & Zip): \_\_\_\_\_

Bank Routing Number (between symbols I: I: on bottom left corner of check): \_\_\_\_\_

Account Number: \_\_\_\_\_ \_\_\_\_\_ Checking \_\_\_\_\_ Savings

**\*\*\*Please attach a voided check or savings deposit slip\*\*\***

### AUTHORIZATION

I, (name) \_\_\_\_\_, authorize Canton-Inwood Area Health Foundation to initiate automatic debit entries to the account at the bank listed above. I authorize the initiation of credit entries, if necessary, to complete adjustments for any duplicate or erroneous entries made in error to the account listed above. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law.

This Authorization Agreement will remain in effect until I notify you in writing to cancel or change it, and in such time, as to afford the financial institution a reasonable opportunity to act on it. By signing this authorization I hereby acknowledge receipt of a copy of this signed Authorization Agreement.

Name (Please Print) \_\_\_\_\_

\_\_\_\_\_  
Signature of Debiting Account Holder

\_\_\_\_\_  
Date

*All gifts are tax deductible to the fullest extent of the law.*