Wellness for all Pooled Trust Inc

Credit Card Authorization Form

Name on Card _____

Card #_____

Expiration ___/____ CCV_____ Zip Code_____

Please note a 3% fee will be deducted when using a credit/debit card.

Direct Debit (ACH) Authorization Form

☐ **NEW REQUEST**

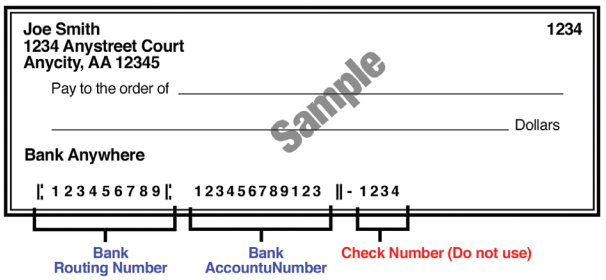
☐ **CHANGE REQUEST**
- ☐ AMOUNT
- ☐ DATE
- ☐ BANK ACCOUNT

Name(s) _____

Bank Name _____

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

Bank Account # _____



☐ Checking ☐ Savings

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

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

Date to Start Debits: 3rd, 15th, 22nd, 28th (circle one)

Monthly Fee: _____ Cancellation/Account Closure Fee $99

☐ Debit One Time Enrollment Fee $197

By signing this form I authorize Wellness for All Pooled Trust 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 payment. 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 WFA a reasonable amount of time to act on it. The cancellation fee s 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 Wellness for all office.

Fax: 716-313-1239