 A global leader in providing technology enabled business solutions and services

AUTHORIZATION AGREEMENT FOR ELECTRONIC WIC PAYMENTS via ACH

**(CONFIDENTIAL)**

Georgia WIC Program Vendors:

Please complete this form to authorize CSC to make electronic payments for certain returned check charges. Verify your bank routing number and account number with your financial institution. Attach a **voided check** from the account into which electronic deposits are to be made.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Fax this form & a copy of the voided check to: | Attn: Office of Vendor ManagementFax: (404)657-29101(866)814-5468 | **OR** | Mail this form & the voided check to: | WIC Office of Vendor ManagementGeorgia Dept. of Public Health2 Peachtree Street, NW – 10th FloorAtlanta, Georgia 30303 |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| WIC Vendor ID No: |  | WIC Vendor Store Name: |  |  |
| WIC Vendor e-mail address: |  |  |
| (for electronic statements) |
| WIC Vendor Contact Name: |  |  |
| **Financial Institution**: |
| Name: |  | (50 characters) |
| Bank Routing Number: |  | (9 characters) |
| Bank Account Number: |  | (25 characters) |
| Address 1: |  | (50 characters) |
| Address 2: |  | (50 characters) |
| City: |  | State (Abbr.): |  | Zip Code: |  |  |
|  | (50 characters) | (2 characters) |  |  | (5-9 characters) |
| The individual signing this form certifies that s/he is authorized to provide bank routing and account numbers on behalf of the WIC vendor and that the information provided is true and correct. |
|  |  |  |  / /  |  |
|  | Signature of Authorized Representative (no initials) |  | Date of Signature |
|  |  |  |  |  |
|  | Printed Name of Representative (no initials): |  | Title of Representative |  |
|  | Phone Number:  | ( \_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |