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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 Management  Fax: (404)657-2910  1(866)814-5468 | **OR** | Mail this form & the voided check to: | WIC Office of Vendor Management  Georgia Dept. of Public Health  2 Peachtree Street, NW – 10th Floor  Atlanta, 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: | | ( \_\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_—\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  | | | | |