ACH MONTHLY MEDICAID SURPLUS WITHDRAWAL AUTHORIZATION

Instructions: This application may be submitted to request automatic withdrawal of your monthly Surplus deposit after three consecutive months of deposit activity. Automatic withdrawal will begin one month or 30 days after an application is approved.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Life's WORC Trust Services in writing of any changes in my account information or termination of this authorization at least **15** days prior to the next withdrawal date. If this communication is not received **15** days prior, requested changes may not go into effect prior to the withdrawal date. If the above noted periodic withdrawal date falls on a weekend or holiday, I understand that the payment will be executed on the next business day.

In the case of an ACH transaction being rejected for Nonsufficient Funds, I understand that Life's WORC Trust Services may at its discretion attempt to process the charge again within 30 days, and I agree to an additional $25.00 charge for each attempt. I agree not to dispute this billing with my bank so long as the transactions correspond to the terms indicated in this authorization form. Should I do so, I understand that Life's WORC Trust Services may take legal action to remediate any resulting overdraft or negative balance.

I affirm that the amount of the requested deposit includes the beneficiary's monthly spenddown as per Medicaid.

Signature: ______________________________

Printed Name: ______________________________

Date: ______________________________

1501 Franklin Ave. I Mineola, NY 11501 I 516.34.TRUST (348-7878) I Fax (516) 519-5218
trustservices@lifesworc.org I www.lifesworctrust.org

Life's WORC | Trust Services

Financial Security for People with Special Needs.

ACH MONTHLY MEDICAID SURPLUS WITHDRAWAL APPLICATION

Date of Request: ________________________________

Beneficiary's Name: ________________________________ (As listed on bank account)

Beneficiary Address: ____

Type of Benefit Rcvd: ________________________________ (Soc. Sec., Pension, Veteran's)

Date Benefits Rcvd: ________________________________

Withdrawal Amount: ________________________________ (monthly spend down amount)

Bank Routing #: ________________________________

Bank Account #: ________________________________

Trust Account #: ________________________________

Signature: ________________________________ (person making request)

Printed Name: ________________________________

Please check one: □ Beneficiary □ Guardian/Advocate □ POA

By signing above I understand that: (1) I am giving authorization to Life's WORC, Inc. and its representatives to access my account monthly to withdraw or debit the amount listed and, if necessary, to initiate adjustments for any transactions credited or debited in error. 2) I am responsible for any fees that may be incurred for insufficient funds, if the account is overdrawn, Life's WORC is not responsible for overdraft fees. (3) Two failed attempts to debit the account will result in termination of this agreement and future Surplus income deposits will need to be mailed to: Trust Services Dept., 1501 Franklin Ave, Mineola, NY 11501. I represent that I have authority over this bank account, and to authorize these transactions. I acknowledge that all transactions must comply with all provisions of U.S. law.

For Office Use Only

Approved by: __________________________ Date: ____________

□Trustee □ Administrator

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