

St. Clair County Community Mental Health  
**Authorization Agreement for Electronic Funds Transfers**

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**Vendor Information:**

Check One:  New Enrollment  Change Account Information

Business Name: \_\_\_\_\_

Tax ID/EIN: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email Address for Remittance: \_\_\_\_\_

**Financial Institution Information:**

Financial Institution Name: \_\_\_\_\_

Address: \_\_\_\_\_

Account #: \_\_\_\_\_ Routing #: \_\_\_\_\_

Account Type:  Savings  Checking

***\*A copy of a voided check or bank confirmation letter must accompany this authorization***

**Authorization:**

I hereby authorize St. Clair County Community Mental Health to deposit my payment into the account listed above. This authority will remain in full force and effect until written notice from me has been received by the company in such a manner as to afford reasonable time to act on it.

Contact Name: \_\_\_\_\_ Job Title: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Please return the completed & signed form by either mail or email with an attached copy of a voided check to:

St. Clair County Community Mental Health  
c/o CONFIDENTIAL – Heather Feher  
3111 Electric Avenue  
Port Huron, MI 48060

Email: [HFeher@scccmh.org](mailto:HFeher@scccmh.org)

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**In Office Use Only:**

Verbal confirmation of banking information change by: \_\_\_\_\_ Date: \_\_\_\_\_

Chief Financial Officer Approval: \_\_\_\_\_ Date: \_\_\_\_\_