

New Jersey Department of Health  
WIC Services  
P.O. Box 364  
Trenton, NJ 08625-0364

AUTHORIZATION AGREEMENT FOR  
DIRECT DEPOSIT (ACH) CREDITS

Stamp Number: \_\_\_\_\_

Store Name: \_\_\_\_\_

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

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Please verify your routing and account numbers with your bank or corporate office before completing this section. **IMPORTANT: If any of this information changes, immediately notify New Jersey WIC Services, by calling a State Agency Vendor Unit representative at (609) 292-9560 or submit by fax at (609) 633-2794.**

Depository Bank Name: \_\_\_\_\_

Branch: \_\_\_\_\_

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

City, State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Routing (Transit) Number: \_\_\_\_\_

Checking Account Number: \_\_\_\_\_

I (We) hereby authorize New Jersey WIC Services to initiate credit entries to my (our) bank account. These credit transactions should be made to the depository bank named above. If funds to which I am not entitled are deposited to my account, I (we) authorize New Jersey WIC Services to direct the financial institution(s) to return said funds.

|  |       |
|--|-------|
| Name of Vendor Authorized Person (Print) | Title |
| Signature                                | Date  |

**Attach a copy of a blank VOIDED check from your account to ensure that your ACH credit is correctly applied.**

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