ACB | American Council of the Blind
Together for a bright future

6300 Shingle Creek Pkwy, # 195
Brooklyn Center, MN 55430
612-332-3242 fax: 763-432-7562

MONTHLY MONETARY SUPPORT PROGRAM

Please use this form to enroll, change existing information, or to request that we contact you.

New Enrollment: _____ Change Existing Enrollment:

Name: _____

Address: _____

_____

City, State, Zip: _____

Telephone: _____

E Mail Address: _____

Deductions are made the 10th or the 22nd of each month. Please select the date each month you wish the deduction to occur:

10th Day: _____ 22nd Day: _____ Date to commence:_____

For New Enrollees:

Enter your total monthly donation amount $_____

For Changes to Your Existing Account (choose only one below):

increase my monthly donation by $ _____

decrease my monthly donation by $_____

Complete this section if you wish to assign a portion of your monthly donation to one state or special interest affiliate. Leave this section blank if you wish to contribute all your monthly donation to ACB:

Affiliate Name: _____

May we inform this affiliate of your donation? Yes: _____ No: _____

For New Enrollees

Enter amount you wish to designate (up to one half of monthly donation):

$_____

For Changes to Your Existing Account (choose only one below):

increase my affiliate donation by $ _____

decrease my affiliate donation by $ _____

Complete this section if you wish to make your monthly donation via credit card:

Credit Card Type:

VISA: _____ Mastercard: _____ Discover: _____ American Express: _____

Credit Card Number: _____

Expiration Date (month/year): _____

Name as it appears on the card (if different from above):

_____

Complete this section if you wish to make your monthly donation via automatic monthly deduction from your bank account:

Checking: _____ Savings: _____

Bank Name:_____

Bank Address:_____

Bank City, ST, Zip: _____

Bank Routing Number: _____(9 digits-usually to the left of account #)

Account Number: _____

The best way to ensure your bank account deduction is set up accurately is to write "void" on one of your checks and attach it to this form.
I hereby authorize the American Council of the Blind (ACB) to draft the amount indicated on this form, each month on the specified date, from my account or credit card as indicated below, as a contribution to ACB. ACB is further authorized to continue to draft funds, as set forth below, until I instruct ACB to alter or cancel this authorization. As an MMS participant, I understand that I can, at my sole option, designate a portion of my ACB monthly contribution (not to exceed one half) to one state or special interest affiliate of ACB, as designated below.
Please sign and date this form:

Authorized By: _____Date: _____

For Minneapolis Office Use Only

	Previous Amount	Amount of Change	New Amount	
ACB Portion	_____	_____	_____	Effective Date of Change: _____
Affilliate Designation	_____	_____	_____	Sponsor Recorded (if applicable):
Total Monthly Donation	_____	_____	_____	_____

Processed By: _____ Date: _____