



NC Community Alternatives Program (CAP) Participant Deductible Payment Agreement

This form authorizes ACH withdrawal of CAP-assigned deductible amount required for self-directed services.

Participant Name	
Date of Birth	

Authorization and Acknowledgment

- I authorize Acumen Fiscal Agent of North Carolina to withdraw my monthly deductible electronically.
- Deductible payments must be received before payroll services can be processed for the applicable month no later than the 25th of the previous deductible month.
- This authorization remains in effect until revoked in writing.
- I will notify Acumen of any banking information changes.
- Failure to maintain deductible payments may affect continued participation under CAP and Medicaid requirements.

Deductible and Banking Information

Monthly Deductible Amount	\$ _____
Account Action	☐ New ☐ Change ☐ Cancel
Account Type	☐ Checking ☐ Savings
Financial Institution Name	
Routing Number	
Account Number	
Preferred Withdrawal Date	
Phone Number	

Participant Certification

Printed Name: _____

Signature: _____ Date: _____

Contact Information

Email: nccapagents@acumen2.net

Fax: 866-463-7589