(In partnership with Harbour Credit Counseling Services Inc.)

FAX this Agreement, Budget Sheet, Creditor List, and ACH Authorization form to:
Fax: (800) 445-4941

Debt Management Agreement

(Please make copies for personal records)

This agreement between ___________________and Harbour Credit Counseling Services, Inc. (HCCS) is entered into on_______ . We (I) hereby employ HCCS to act as our (my) agent in arranging and making payments to our (my) creditors under our (my) debt reduction plan. We (I) agree to cooperate to the fullest extent of our (my) ability with HCCS in every respect with regard to these obligations and grant HCCS full authority to adjust, arrange, change, satisfy, or settle any and all debts listed with them on our (my) behalf. We (I) affirm that all information given to HCCS in this regard is complete and accurate. We (I) also grant HCCS permission to disclose as much of our personal financial information as is necessary to satisfy our (my) creditors and release creditors to provide information to HCCS.

We (I) agree to pay HCCS the total monthly amount for disbursement from HCCS until the sum of _______ , which is the current principal balance amount listed on our debt analysis, has been liquidated. On average debt liquidation should be completed in 5 years or less, based on current balances and payment given. We (I) understand that the amounts may be modified if new creditors are added or if we (I) need to adjust our (my) payment schedule.

My (our) monthly total amount includes a donation of $______ to HCCS, a non-profit organization. All other funds are to be disbursed to our (my) creditors*
**May differ dependent upon state restrictions.*

Initial Setup Fee………	$__________________
Monthly Amount...........	$__________________
Monthly Fee.................	$__________________
Total Monthly Amount	$__________________

We (I) affirm that the payment arranged is within our (my) ability to pay. This declaration based on the following Budget Analysis.

Monthly Income…………………………………...	$____________________
Minus Monthly Expenses…………………………. *(Not including HCCS total monthly amount)*	$____________________
Funds available to pay HCCS total monthly amount.. *(Should be no less than Total Monthly Amount in above section)*	$____________________

We (I) hereby grant HCCS the authority to use their best judgment to determine what obligations shall be paid in the event there are insufficient funds available to meet the entire plan. It is agreed that either party may cancel this agreement with thirty (30) days written notice to the other. We (I) understand, through a discussion with a HCCS Counselor, that we (I) lose the ability to use credit cards that are part of this debt reduction program and that notations may appear on our (my) credit report which indicate that we are (I am) in a debt plan status.

We are (I am) neither insolvent nor bankrupt nor do we (I) have any attachments of any kind, repossessions, garnishments, or wage assignments pending. We (I) have filled in the debt analysis and carefully read this agreement prior to signing it and hereby affirm that no other inducements were made or offered to enter into this agreement. We (I) understand that we may examine our accounts in your office during normal business hours. We (I) further affirm that the payments arranged are reasonably within our (my) ability to pay.

______________________	______________________	______________
(Client Signature)	*(SSN#)*	*(Date)*
______________________	______________________	______________
(Client Signature)	*(SSN#)*	*(Date)*

5100 S. Cleveland Avenue Suite 318
Ft. Myers, Florida 33907
Phone: (800) 476-4919
Fax: (800) 445-4941

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Application Information Sheet

GENERAL INFORMATION

Name: ____________________ Social Security: #_____ - ___ - ______
Spouse: ___________________ Social Security: #_____ - ___ - ______
Address: ____
City: __________________________ State: _______ Zip:____________
Home Telephone: (___)_____ - __________ Work Telephone: (___)____ - _______
Dependents in Household:_________ E-Mail Address: _______________________

MONTHLY BUDGET ANALYSIS

(Required by creditors)

Expenses		Total Net Income	
Rent Payment $_______.	Insurance: Life $_______.	Applicant	$_______.
Mortgage Payment $_______.	Auto $_______.	Co-Applicant	$_______.
Automobile: Payments $_______.	Home $_______.	Retirement	$_______.
Gasoline/Oil $_______.	Medical $_______.	Social Security	$_______.
Household (grocery) $_______.	Medical Expenses $_______.	Child Support Income	$_______.
Utilities: Gas $_______.	Child Support $_______.	AFDC	$_______.
Electric/Cable $_______.	Childcare/Daycare $_______.	Food Stamps	$_______.
Water/Sewage $_______.	Misc./Charities $_______.	TOTAL	$_______.
Phone/Cellular $_______.		Less (subtract) Expenses	$_______.
Total Monthly Expense $___________.		Estimated HCCS Min Payment	$_______.
		Available Balance	$_______.

Reason for Debt Management Program: (MUST Check most appropriate)
( )Poor management ( )Divorce ( )Death in family ( )Reduced income ( )Medical/Disability ( )Confidential
Balance of Unsecured Debt $___________ Regular Monthly Payments $___________
Balance of ALL Secured Debt $___________ Est. Assets $___________ Est. Liabilities $___________

Instructions:

- **Complete BOTH this application and the creditor form.**
- **For verification of accuracy, include *CURRENT COPIES* of most recent creditor statements**
- Sign the Credit Management Agreement,
- SPECIAL NOTE: You may need to change the due dates and cancel credit card insurance to avoid increases in fees and finance charges. Your account advisor will assist you in selecting the most appropriate payment date.
- Enclose your estimated Total Monthly Payment Amount, and ***return*** all of the above information either by mail or fax.
- If FAXING these documents, you must immediately follow with a check or money order for the estimated HCCS amount. Print your name and social security number clearly with your payment. Please *note that checks require a 10 day holding period before dispersing.*
- **Remember, in a debt management plan** you are required to close all existing accounts (except those needed for business purposes).
- You must avoid additional debt.

Payment Information:

Your initial payment is to be made by either check or Money Order payable to HCCS TRUST. Your name and social security number must be clearly printed. Processing for your Debt Payment Plan application can *not* begin until your Estimated Total Monthly payment is received.

(THIS FORM IS PART OF THE DEBT MANAGEMENT AGREEMENT)

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Listing of Creditors

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Name of Creditor:______________________________ Account #______________________________
Address:____ Phone:(______) _________ - ______________
City:__________________________ State:______________ Zip:__________________
Balance:$_______________________ Due Date:______/______/______ Monthly Payment:$___________

Print additional copies of this sheet if you have more than 6 creditors to list.
**** For verification of accuracy, include *current copies* of most recent statements ****

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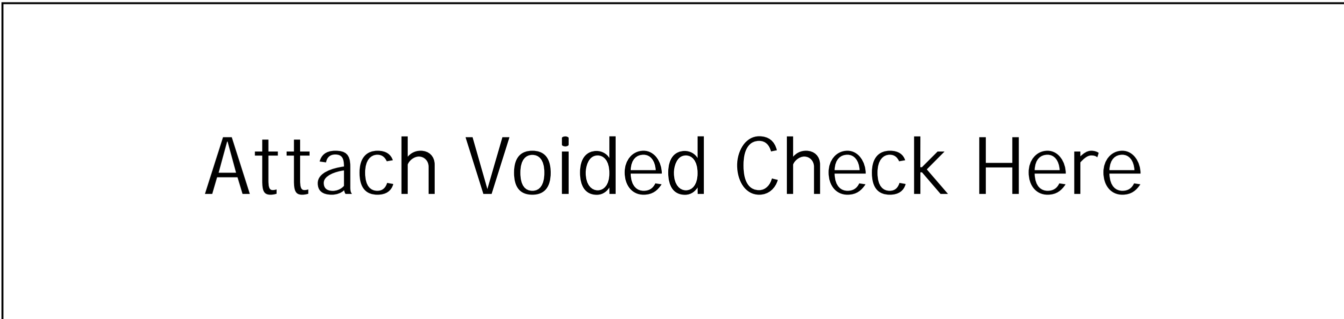
AUTOMATIC CHECKING AUTHORIZATION

I hereby request and authorize the following Automatic Checking Authorization made with Harbour Credit Counseling Services Inc.:

Client Name(s):___________________________________ SSN:_______ - _____ - ________
Address:____
City:_____________________ State:________ Zip:___________ Telephone:(_____)______ - _______

Please *(Check One)* : Debit my ____ Checking Account ____ Savings Account

A current, unsigned, voided check MUST be attached in the box below in order to process.



We (I) have selected the Automatic Checking Debit option and authorize Harbour Credit to withdraw or "debit" the monthly amount of $_______from the above bank account starting the month of _____________. Please check one:

( ) Please withdraw on the 2nd
( ) Please withdraw on the 5th
( ) Please withdraw on the 9th
( ) Please withdraw on the 12th
( ) Please withdraw on the 16th
( ) Please withdraw on the 19th
( ) Please withdraw on the 23rd
( ) Please withdraw on the 26th

Termination from Automatic Checking:
Harbour Credit Counseling Services Inc. will terminate or change debits from our (my) bank account only upon our (my) written request at least **7 days** prior to the next scheduled debit date. We (I) acknowledge that if Harbour Credit Counseling Services Inc. does not receive that notice in the allotted time, **Harbour Credit Counseling Services Inc. cannot guarantee** that the Total Monthly Amount will not be debited from our (my) account. Furthermore, due to Harbour Credit Counseling Services's Non-Profit status, Harbour will not be responsible for overdraft fees caused by automatic debits. Funds debited from our (my) bank account and all other payments made to Harbour Credit Counseling Services Inc. for payment of the Listed debts will not be returned to us (me) at any time for any purpose. However, funds will be paid to the creditors on the Creditors List to pay or reduce our (my) Listed Debts.

Insufficient Funds:
In the event of insufficient funds the client agrees to immediately submit a money order for the monthly payment plus a $25.00 NSF* charge. Automatic checking will continue the following month. **May differ dependent upon state restrictions.*

Holding Period:
We (I) acknowledge that Harbour Credit Counseling Services Inc. is required to hold all automated checking payments for **3 business days** before disbursing to my (our) listed debtors.

Client Signature_____________________________________ Date:_______________

A Licensed Non Profit Agency