## Veteran Directed Care Program Non-Payroll Reimbursement Request

Veteran Name:	So	Social Security #://	
Did the participant ha	ve a hospital or nursing home stay during any of thes the dates the participant was admitted to and discharg	e dates? Yes \(\sime\) No ged from the Hospital:	
Date of Service	Indicate if Service, Goods or Cash (please attach receipts, invoices, order for		Amount to be Paid
			_
			11 0
	up expenditures not included in the budge VA Coordinator.	et must be approve	ed by Care
	the total expenses exceed my approved all ns will not make full payment on my requ		, I understand
ndor Signature:	ignature:	Date: Date:	

Send to:

**ARIS Solutions** 

P.O. Box 4409

White River Jct., Vermont 05001 **QUESTIONS?** 

Phone:1~866~970~3301

Fax:1-802-295-9812 Email: veteranpayroll@arissolutions.org