

FLEXIBLE CHOICES NON-PAYROLL REIMBURSEMENT REQUEST

			
the consum	ER NAME: ner have a hospital or nursing home stay during any of these dates? You	esNo	
YES, please indicate the dates the consumer was admitted to and discharged from the hospital.			
*DATE	Indicate if SERVICE, GOOD or CASH (please attach receipts, invoices, order forms)	CASH ✓ if yes	AMOUNT TO BE PAID
Chaola ha	are if these purchases are to be reid for out of sevings		
	ere if these purchases are to be paid for out of savings. nat the total expenses for this bi-weekly period exceeds my app	oroved allocati	on or savings, I under
me event u	l not make full payment on my request.		
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SEND TO: TRANSITION II 346 SHELBURNE RD BURLINGTON, VT 05401

QUESTIONS CALL: 1-800-798-1658

FAX TIME SHEETS TO: 1-888-604-0361 E-MAIL TIME SHEETS: ARIStime@arissolutions.org