Veteran's Independence Program
Non-Payroll Reimbursement Request

Check Payable to:_____

Address:_____

Participant Name:_____ Social Security #: ____ / ____ / ____

Did the participant have a hospital or nursing home stay during any of these dates? Yes ☐ No ☐
If YES, please indicate the dates the participant was admitted to and discharged from the Hospital._____

Date	Indicate if Service, Goods or Cash (*please attach receipts, invoices, order forms)*	Cash √ if yes	Amount to be Paid

___ Check here if these purchases are to be paid from planned savings.
___ Rainy Day expenditures not included in the budget. Must be approved by Care Advisor.
_____Care Advisor Signature

In the event that the total expenses exceed my approved allocation or savings, I understand that ARIS Solutions will not make full payment on my request.

Provider Signature:_____ Date:_____
Employer Signature:_____ Date: _____
Print Employer Name:_____

Payment requests must be submitted every two weeks according to the pay schedule. Payment requests received more than two months after the service was provided or purchase was made cannot be paid.

Send to: ARIS Solutions
P.O. Box 4409
White River Junction, Vermont 05001 QUESTIONS? CALL 1-866-970-3301