



**ARIS Solutions**  
**P.O. Box 4409**  
**White River Jct., VT 05001**

**Department of Disabilities, Aging and Independent Living**  
**Adult Services Division**  
**COVID Payment Request**

Date:			
Check Payable to:			
Mailing Address:			
Participant's Name:			
Relationship to Participant:			
Pay Period:			
Hours of Personal Care Requested:		Rate:	
Hours of Companionship/Respite Requested:		Rate:	

***By signing this form, I attest that I am the employer of services for this participant and currently reside in the same home as the participant.***

**Signature:**

Date:	Phone Number:

***ARIS Solutions will provide a Form 1099 related to Adult Service Division COVID Payments to report this income on individual 2020 income taxes if applicable.***