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

Vermont Department of Health
Children's Personal Care Services
COVID Payment Request

Date:	
Check Payable to:	
Relationship to Child:	
Mailing Address:	
Child's Name:	
Pay Period Covered	
Child's Authorized Hours per Week:	
Total Hours Requested:	

DCF Foster Parents & DAIL Shared Living Providers are not eligible to receive this stipend

I (below) certify, under the pains & penalty of perjury, that I have provided direct care to the above-named child for the hours requested on this form and am the authorized to sign this form for the purposes of obtaining payment for said services

Signature:

Date:	Phone Number:

For ARIS Use Only	Total Hours:		Total Payment: