ARIS Solutions Fiscal Agent
ENROLLMENT OR CHANGE OF INFORMATION

TBI Respite Program

*** ENROLLMENT_____ REVISION_____ TERMINATION_____**
***EFFECTIVE DATE OF CHANGE OR ENROLLMENT_____**

Participant Information

* Participant Name_____ *Social Security #_____
* Address_____ *Telephone # _____
_____ * Medicaid Unique ID _____
*ICD-10 Code:

TBI Respite

*Employer Name (if different from the Participant): _____
*Address_____ *Telephone # _____
_____
*Start Date:_____ End Date_____

*Total Funds Allotted For the Above Period: _____

Agency Information

*Agency Name _____ Telephone # _____

*Contact Person _____ Telephone # _____

The undersigned does herby authorize ARIS Solutions to pay any and all invoices submitted up to the amount specified above and agrees that within five business days of receipt of invoice, payment will be made to ARIS Solutions by direct deposit. The undersigned also agrees to pay ARIS Solutions a monthly administrative fee per active participant per month by direct deposit.

*_____ _____
Agency Authorized Signature Date

All sections with ***** must be completed.

Complete all pertinent sections of this form and mail or fax to:

ARIS Solutions Telephone: 1-802-295-1658
PO Box 4409 Fax #: 1-802-295-0663
White River Jct., Vt. 05001

Agency Notes:

_____

_____

Note: Termination of consumer and/or employer is a critical event which requires immediate notification to ARIS Solutions. Until such notification is received by ARIS Solutions payment will continue to be made on behalf of the participant up to the total allocation.