

# Foster Parent Monthly Transportation Reimbursement Form

Foster Parent \_\_\_\_\_

For Period Ending \_\_\_\_\_ 15<sup>th</sup>, 200\_\_

Address \_\_\_\_\_

Date \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Foster Parent ID# \_\_\_\_\_

Please complete for each child in your home for whom you have provided reimbursable transportation (i.e. medical appointment, dental appointments, vision appointments, counseling and mental health appointments, and visitation (as authorized). For all medical, dental, vision, counseling and mental health transports, you are **REQUIRED** to write the name of the doctor or treatment professional on the reimbursement form. **Reason for Visit** **MUST** be filled in to be paid for transportation services (i.e. Counseling, Doctor, Dentist, Authorized Visit).

Foster Child _____	ID# _____	Social Worker: _____
Foster Child _____	ID# _____	Social Worker: _____
Foster Child _____	ID# _____	Social Worker: _____

Date	Foster Child's Name	Transportation To (Doctor's Name, Medical Facility, <u>Authorized</u> Visit location, etc.)	Reason for Visit (i.e. Doctor, Counseling, Authorized Visit).	Amount
<b>Grand Total</b>			<b>\$</b>	

I certify that the information listed above is true, accurate and complete. I understand that payment and satisfaction of this claim will come from federal and state funds and any false claims, statements, or documents, or concealment of material fact, may be prosecuted under applicable federal or state laws.

Signed \_\_\_\_\_  
(Foster Parent)

Report period is from the 16<sup>th</sup> of the month to the 15<sup>th</sup> of following month. Reports must be at the following address by the 20<sup>th</sup> of the month to be paid on current month.

**Submit to: DCYF, ATTN: Business Office, 101 Friendship St 4<sup>th</sup> Floor, Providence RI 02903**