Foster Parent Monthly Transportation Reimbursement Form

Foster Parent _____ For Period Ending _____ 15th, 20___

Address _____ Date _____

City/State/Zip _____ _____ _____

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, Authorized Visit location, etc.)	Reason for Visit (i.e. Doctor, Counseling, Authorized Visit).	Amount
Grand Total			$	

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 16th of the month to the 15th of following month. Reports must be at the following address by the 20th of the month to be paid on current month.

Submit to: DCYF, ATTN: Business Office, 101 Friendship St 4th Floor, Providence RI 02903