Rhode Island DCYF Reimbursement Transportation Program

Reimbursement Form

In August 2006, The Rhode Island Department of Children, Youth and Families (DCYF) instituted the Travel Reimbursement Program and implemented it as an incentive to foster parents to assist the social case workers with transporting children to and from appointment and approved visits with their parents

The Following Visits **ARE** Reimbursable

- Medical appointments
- Dental appointments
- Vision appointments
- Counseling & Mental Health appointments

The Following are **NOT** reimbursable

- WIC appointment
- Court appointments
- School Meetings
- Trips to/rom mall, shopping, groceries, etc.
- Trips to/from the hair salon, barber shop
- Trips to/from school, extracurricular activities, etc.
- Multiple reimbursements for appointment located in the same building /parking lot.

- The reimbursemenr rate is $20.00 per round trip, Not $20.00 each way.
- If one or more children are transported to the same appointement visit, you will only be reimbursed for one child as the reimbursement rate is per round trip and not per child being transported.
- If you transport the child only one-way the reimbursemnt rate is $10.00.
- If the child has more then one appointment per day, you may submit for mutiple round trips however you must physically drive the child to/from each appointment.
- Ie: Child has a well-being check a the peditricians office and then needs bloodwork and both appointments are in the same building, that is counted as 1 trip.

When completing the form, you are REQUIRED to write the name of the doctor/provider as well as the reason for the appointment.

Printable Form

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