Transportation Reimbursement Program

In August of 2005, The Department of Children, Youth and Families (DCYF) introduced the Travel Reimbursement Program. This program was implemented as an incentive to foster parents to assist social caseworkers with transporting children to and from appointments and approved visits with their parents.

The following are reimbursable:

- Medical appointments
- Dental appointments
- Vision appointments
- Counseling and mental health appointments
- *Authorized* visitation

The following are <u>not</u> reimbursable:

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

The reimbursement rate is $20.00 per round trip, NOT $20.00 each way. Also, if one or more children are transported to the same appointment/visit, you an only be reimbursed for one child as the reimbursement rate is per round trip not per child being transported. If you transport the child one way, the reimbursement rate is $10.00. If the child has more than one appointment per day, you may submit for multiple round trips however you must physically drive to/from each appointment.

i.e. child has a well-being check at the pediatrician's office and then needs blood work bit both appointments are in the same building.

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

If you have any questions or require clarification/assistance, please contact the child's social worker or Mary Ann Andrade, DCYF Business Office @ (401) 528-3649.

Foster Parent Monthly 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 the transportation services (i.e. counseling, doctor, dentist, authorized visit).

Foster Child: _____ ID# _____ Social Worker: _____

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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 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 persecuted under applicable federal or state laws.

Signed: _____ (Foster Parent)

Report period is from the 16th of the month to the 15th of the following month. Reports must be at the following address by the 20th of the month to be paid on current month: DCYF. Attn: Business Office, 101 Friendship St., 4th floor, Providence, RI 02903.