

# Foster Parent Monthly Inter-jurisdictional School Transportation Reimbursement Form

Foster Parent: (Enter Name Here)

For Period Ending: (Enter date here - date must end the 15th of the Month. Ex. July 15, 2011)

Address: (Enter Street Address Here)

Date: (Enter Today's Date Here)

Apartment/Floor:

City: (Enter City Here)

State: State    Zip Code:

Telephone Number: (Enter Phone Number Here)

Please complete for each child in your home for whom you have provided reimbursable transportation to a school outside of your jurisdiction. If you transport more than one child to the same school, you may only reimburse for one of the children. The reimbursement is for total miles driven for the transport to and from school.

Foster Child:

Social Worker:

Foster Child:

Social Worker:

Foster Child:

Social Worker:

Date	Foster Child's Name	Name and Location of School	Number of Miles
<b>Total Miles</b>			
Reimbursement Rate will be calculated at the State Mileage Rate (                    )			
<b>Total Reimbursement</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 the following month. Reports must be received 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**