

Department of Human Services

Jackson Child Welfare Office P.O. Box 1549 Medford, OR 97504 (541) 776-6120 Fax (541) 776-6063 Toll Free (866) 840-2741

Dear Foster Parent(s):

On May 1st, 2013, Jackson Branch Child Welfare will begin to implement a Statewide Policy driven change. This is a new method of reimbursing foster parents for **medical transportation** (mileage and meals) costs ONLY. With this pilot, TransLink will be responsible for the reimbursement directly to foster parents.

The new process requires foster parents to contact TransLink for prior authorization for all medical transportation trips in order to get reimbursed. At the appointment, the foster parent will have the provider sign an Appointment Verification Sheet which the foster parent will need to submit to TransLink to initiate reimbursement.

With this new program, foster parents will receive all reimbursements for medical transportation on a debit card instead of a check. Once reimbursement requests have been processed, the money will be deposited into the "AccelaPay Debit Card" on a weekly basis.

To order the debit card or if you have questions about the new process, please contact TransLink at (541)842-2060 or toll free at 1(888)518-8160. The TransLink Transportation Guide, appointment verification sheets, and new reimbursement forms can be found at: http://www.rvtd.org/translink.php. Click on the "TransLink" tab and find the "Reimbursement" category on the left side of the screen. Our branch will keep a supply of Appointment Verification Sheets available for our foster parents and also mail out a supply of them when we send the child's medical card upon placement.

Our branch will be supplying each foster parent with Appointment Verification Sheets when foster home is certified. When a child is placed in your home, you may either download the forms directly from the website, give the office a call and we will mail them out to you OR you may come in and pick them up at any time. Mayra Pena, 541-776-6120 Ext. 207 is our Medical Specialist and should be alerted if you run into any issues with Translink so that we can do our best to advocate for you.

<u>For all long distance medical LODGING</u>—, the hotel stays will still be done for you by the local office (Leann Wolf, our Financial Specialist 541-776-6120 Ext. 276) in advance. We believe this will be a smooth transition as we have already had several of your peers "piloting" this and have had nothing but good communication with Translink. Thank you in advance for your cooperation and understanding! If you have any questions please feel free to call either Mayra or Leann at the above listed numbers.

Sincerely,

Pattie Cavinder

Pattie Cavinder

Jackson Child Welfare Office Manager

Transportation Reimbursement Program



Contact TransLink at -

NUMBERS:

541-842-2060® (Voice)

888-518-8160@ (Toll Free)

541-734-9292® (TTY)

WEBSITE:

http://www.rvtd.org/translink.php

TransLink Medicaid Medical Appointment Verification Form

<u>Please complete one (1) sheet for each of your appointments.</u> All your trip requests must be prior authorized (OAR 410-136-0300) through TransLink to qualify for reimbursement; Original verification sheets (NO COPIES OR FAXES) accepted 30 days from appointment. Separate sheets by cutting along the dotted line. Send only completed sheets.

INCOMPLETE SHEET		
		(Toll Free) 1.888.518.8160
Medical Appointment Verification Sheet		Complete ALL Sections - One Per Appointment
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Doctor/Clinic/Facility Name:	•	Physician Seen:
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Physician or Authorized Representatives Signature Date		
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Client Name:	OHP ID:	DOB (mm/dd/1777):	
Doctor/Clinic/Facility Name:	_	Physician Seen:	
Address:	·	Appt. Duration (h:mm):	<u> </u>
Appt. Purpose:	_		
Appt. Date: Appt. Time:			
Physician or Authorized Representatives Signature Date	<u> </u>		
Medical Appointment Verification Sheet		Complete ALL Sections	- One Per Appointment
Client Name:	OHP ID:	DOB (mm/dd/yyyy):	
Doctor/Clinic/Facility Name:		Physician Seen:	
Address:		Appt. Duration (h:mm):	<u></u>
Appt. Purpose:	-		
Appt. Date: Appt. Time:			
	<u></u>		
Physician or Authorized Representatives Signature Date			