STATE INSTITUTION CLAIMS PROGRAM FORM

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This form is available at http://myfloridalegal.com under the "Programs" heading.

INSTRUCTIONS: This document must be signed by a delegate of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, the Department of Corrections, or the Agency for Persons with Disabilities. The purpose of this document is to ascertain restitution information for property damages and/or direct medical expenses for injuries caused by shelter children, foster children, escapees, inmates, or patients of state institutions or developmental disabilities centers. Fill out this form completely (please type or print legibly), attach all required documentation, and submit to the address shown above. The claim form must be received by the Office of the Attorney General within 120 days of the incident upon which the claim is based. Failure to file within the prescribed timeframe will result in a denial of the claim.

SECTION ONE: CLAIMANT/APPLICANT INFORMATION

1. Claimant's Name (last, first, middle):_____
2. Claimant's Street Address:_____
3. City:_____ 4. State:_____ 5. Zip Code:_____
6. Claimant's Telephone Number:(_____)_____ 7. Alternative Phone Number:(_____)_____

If the claimant is under the age of 18, incompetent, or deceased, the applicant filing on behalf of the claimant must provide information below.

8. Applicant's Name (last, first, middle):_____
9. Relationship to Claimant (check one):
   ☐ Parent ☐ Foster Parent ☐ Legal Guardian ☐ Estate Representative ☐ Other (explain)
10. Applicant's Street Address:_____
11. City:_____ 12. State:_____ 13. Zip Code:_____
14. Applicant's Telephone Number:(_____)_____ 15. Alternative Phone Number:(_____)_____

By my signature, under penalty of perjury or fraud, I certify that the information contained herein is true and correct to the best of my knowledge.

16. Signature:_____ 17. Date:_____

SECTION TWO: RESTITUTION INFORMATION

1. Name of Person Responsible for Loss Incurred (last, first, middle):_____
2. Supervising State Facility (check one):
   ☐ Department of Children and Families ☐ Department of Health ☐ Department of Juvenile Justice ☐ Department of Corrections ☐ Agency for Persons with Disabilities
3. Adjudication of Person Responsible for Loss (check one):
   ☐ Shelter Child ☐ Foster Child ☐ Escapee ☐ Inmate ☐ Patient of a State Institution or Developmental Disabilities Center
4. Date of incident:_____
5. Type of Restitution Requested (check one): ☐ Property Damages ☐ Medical Expenses

6. List each loss and specify the repair/replacement cost. Attach itemized receipts, bills, or estimates of repair which verify the requested amount. The maximum award for losses caused by a foster child shall not exceed $1500.00. The maximum award for losses caused by all other persons supervised by the state shall not exceed $1000.00.

_____ $_____

_____ $_____

_____ $_____

7. Provide a brief statement of the facts upon which the claimant seeks restitution for property damages and/or medical expenses, or attach the agency incident report.

SECTION THREE: STATE AGENCY DELEGATE INFORMATION

1. Department/Section/Division:_____

2. Delegate's Name:_____

3. Agency's Street Address:_____

4. City:_____ 5. State:_____ 6. Zip Code:_____

7. Agency's Telephone Number:(_____)_____ 8. Delegate's Telephone Number:(_____)_____

9. Delegate's Position Title:_____

10. Delegate's Supervisor's Name:_____ 11. Supervisor's Telephone Number:(_____)_____

12. State Agency Delegate Verifications:

(a) I affirm that the attached application meets the requirements of Section 402.181, Fla. Stat.
(b) I affirm that the claimant/applicant has been notified of all applicable rules and regulations for requesting and collecting restitution from the State agency supervising the named person responsible for the property damages and/or medical expenses.
(c) This claim form is being submitted to the Office of the Attorney General within 120 days from the date of the incident.
(d) I affirm that the person named responsible for the property damages and/or medical expenses was under the supervision of the Department of Children and Family Services, the Department of Health, the Department of Juvenile Justice, the Department of Corrections, or the Agency for Persons with Disabilities at the time of the incident.
(e) I understand that it is the responsibility of the State agency delegate to ensure that all information necessary to determine eligibility is provided.

By my signature, I attest to the facts provided regarding this incident and believe the information contained herein is accurate to the best of my knowledge.

13. Signature:_____ 14. Date:_____

To appeal a decision made by the Office of the Attorney General, the claimant must request a hearing, in writing, within 21 days following notification of the adverse decision pursuant to Section 120.57, Fla.Stat., and 28-5 F.A.C.