## STATE INSTITUTION CLAIMS PROGRAM FORM



The Capitol, PL-01 • Tallahassee, FL 32399-1050 Office: (800) 226-6667 • Fax: (850) 414-6197 TDD users may call through Florida Relay Service at 1-800-955-8771 Email Address: vcintake@myfloridalegal.com

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.

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SECTION ONE: CLAIMANT/APPLICANT INFORMATION		
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:		
10. Applicant 3 Silver 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		
Name of Person Responsible for Loss Incurred (last, first, middle):		
2. Supervising State Facility (check one):  Department of Department of Children and Families Health Department of Juvenile		
3. Adjudication of Person Responsible for Loss (check one):  Shelter Foster Escapee Child	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	

	ed receipts, bills, or estimates of repair which verify the requested amount. eed \$1500.00. The maximum award for losses caused by all other persons
	\$
	\$
	<u>\$</u>
7. Provide a brief statement of the facts upon which the claimant seeks agency incident report.	restitution for property damages and/or medical expenses, or attach the
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:()
P. Delegate's Position Title:	
	11. Supervisor's Telephone Number:()
12. State Agency Delegate Verifications:	
the State agency supervising the named person responsible for (c) This claim form is being submitted to the Office of the Attorne (d) I affirm that the person named responsible for the property dam of Children and Family Services, the Department of Health, the Agency for Persons with Disabilities at the time of the incident	the property damages and/or medical expenses.  y General within 120 days from the date of the incident.  ages and/or medical expenses was under the supervision of the Department of Department of Juvenile Justice, the Department of Corrections, or the
By my signature, I attest to the facts provided regarding this incident knowledge.	t and believe the information contained herein is accurate to the best of my
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.