STATE INSTITUTION CLAIMS PROGRAM FORM

Florida Department of Juvenile Justice
Bureau of Finance and Accounting
2737 Centerview Drive, Suite 2300 • Tallahassee, FL 32399-3100
Office: (850) 921-2046 • Fax: (850) 487-3609
TDD users may call through Florida Relay Service at 1-800-955-8771
Email: fin-acctdirectors@fldjj.gov
This form is available at https://www.djj.state.fl.us/partners-providers-staff/forms-library

INSTRUCTIONS:

This form complies with section 402.181, Florida Statutes, and is used to ascertain restitution information for property damage and direct medical expenses caused by escapees or residents of Department of Juvenile Justice facilities.

For a claim to be considered, this form must:

1. Be completely filled out, signed, and dated by the claimant or legal representative;
2. If completed by a legal representative, include documentation to prove the relationship with the claimant;
3. Fully describe the restitution amount per Section 2 and attach related documentation;
4. Fully describe the property damage or medical expenses in Section 2 and attach related documentation; and
5. Be received at the office address or email address shown above within 90 calendar days of the incident. Failure to timely submit a complete form will result in denial of your claim.

SECTION 1: CLAIMANT / LEGAL REPRESENTATIVE INFORMATION

1. Claimant's Name (last, first, middle): _____

2. Claimant's Mailing Address: _____

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

6. Claimant's Telephone Number: ( )_____ 7. Claimant's Email (optional): _____

If the claimant is under the age of 18, incompetent, or deceased, the legal representative filing on behalf of the claimant must provide information below:

8. Legal Representative's Name (last, first, middle): _____

9. Relationship to Claimant (check one):
   ☐ Parent ☐ Foster Parent ☐ Legal Guardian ☐ Estate Representative
   ☐ Other (explain):_____

10. Legal Representative's Street Address: _____

11. City: _____ 12. State: _____ 13. Zip Code: _____

14. Legal Representative's Telephone Number: ( ) _____

15. Legal Representative's Email (optional): _____

SECTION 2: RESTITUTION INFORMATION

1. Location of Incident: _____

2. Date and Approximate Time of Incident: _____

3. Type of Restitution Requested: ☐ Property Damages ☐ Medical Expenses

4. List each injury/loss and specify the repair/replacement cost. You must attach itemized receipts, bills, or estimates of repair which verify the requested amount. The maximum award for losses caused by all persons supervised by the Department shall not exceed $1,000 per incident.

Description of Each Loss (Property Damages or Medical Expenses)	Amount
	$
	$
	$

5. Provide a statement describing the facts upon which the claimant seeks restitution. Attach additional pages as necessary. You must attach documentation supporting the facts described below. Documentation may include photograph(s), police report, witness statement(s), etc.

6. Have you sought compensation for loss or injury through workers' compensation, private insurance, or any other indemnification related to this incident? ☐ Yes ☐ No
   If yes, explain: _____

By my signature, under penalty of perjury and fraud, I certify that the information contained herein is true and correct to the best of my knowledge. I acknowledge that any individual who submits a claim containing documentation that has been falsified or that contains misrepresentations shall be held liable under the False Claims Act pursuant to sections 68.081 – 68.092, Florida Statutes.

_____ _____

Signature Date