STATE INSTITUTION CLAIMS PROGRAM FORM

Agency for Persons with Disabilities
4030 Esplanade Way Suite 360 • Tallahassee, FL 32399-0950
Office: (850) 414-6582
TDD users may call through Florida Relay Service at 1-800-955-8771
Email: InstitutionClaimsForms@apdcares.org

INSTRUCTIONS: Pursuant to section 402.181, Florida Statutes, the purpose of this document is to ascertain restitution information for property damages and/or direct medical expenses for injuries caused by residents of Tacachale, Sunland Center, the Developmental Disabilities Defendant Program ("DDDP"), and Pathways under the supervision of the Agency for Persons with Disabilities ("Agency").

For this Claim Form to be considered complete it 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. In Section B, #4., fully describe the injury/loss and restitution amount and attach related documentation;
4. In Section B, #5., fully describe the incident resulting in property damage and/or injury 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 A: 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): ______________________________

Only complete 8. through 15. if Legal Representative is filing this form on behalf of Claimant.

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

9. Relationship to Claimant (check all that apply and you must attach documentation to prove the relationship):

☐ Parent ☐ Foster Parent ☐ Guardian ☐ Estate Representative ☐ Power of Attorney

10. Legal Representative 's Mailing Address:______________________________

11. City:____________________ 12. State:__________ 13. Zip Code:____________

14. Legal Representative's Phone Number:(________)______________________________

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

SECTION B: RESTITUTION INFORMATION

1. Location of Incident (including address):______________________________

2. Date and Approximate Time of Incident:______________________________

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

4. List each injury and/or loss and specify the health care, repair and/or replacement cost. Attach itemized receipts or estimates that show the health care, repair and/or replacement cost.

Description of Each Loss (Include relevant details: For *property damage*: purchase price, product name, model number, and any unique qualities. For *direct medical expenses*: co-pay(s) and other uncovered service(s)/product(s) like procedures, prescriptions, and other over-the-counter items.)	Amount for Replacement, Repair, or Direct Medical Expenses
	$
	$
	$

5. Describe in detail the incident that resulted in the property damage or injury. Attach additional pages as necessary. Attach documentation which supports your explanation, such as photographs, police reports, witness statements, and similar documents.

6. Have you filed a claim or requested reimbursement from workers' compensation, any type of insurance, or any other person or entity for this incident? ☐ Yes ☐ No

If yes, explain:______________________________

I certify that the information contained herein is true and correct to the best of my knowledge. I further 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:______________________