Policy/Procedure/Subject: Foster Parent Damage Claims Reimbursement		
Policy/Procedure No: AP 444	**Adoption Date:** 08/01/03	**Revision Date:** 10/20/16
Approved By:	**Title: Chief Executive Officer**	
Authority Reference: Governing Board		

I. POLICY

This operating procedure outlines the procedure to follow when an individual wishes to seek restitution for direct medical expenses and/or property damage caused by a shelter or foster child.

II. APPLICATION

All Children's Network of SWFL, LLC expenditures.

III. PROCEDURE

A. The following distinctions determine the allowable amounts for reimbursement. At the time the injury or damage occurred, if the child responsible was:

1. In shelter legal status [pursuant to a court's shelter order], restitution up to $1,000.00 may be claimed.

2. In foster care legal status[pursuant to a court order granting custody to the department for placement in foster care], restitution up to $1,500.00 may be claimed.

B. The living arrangement, i.e., shelter or foster home or residential group care, has no bearing on the above distinction; it is based solely on the child's legal status at the time the injury or damage occurred.

C. When a shelter parent, foster parent or other individual advises the assigned Case Management Organization (CMO) staff member of expenses they have incurred as a result of personal injury or property damage caused by a shelter or foster child, the CMO case manager will:

1. Assist the claimant in completion of the Restitution Claim Form (Exhibit A).

2. Ensure that the form is completed in its entirety and that legible receipts (or estimates) from a licensed vendor are attached.

3. Review the circumstances of the claim and have the claimant sign the form.

a. If the staff member reviewing the circumstances does not agree that the shelter or foster child was responsible for the injury or property damage, the staff member should note that opinion on the signature line.

b. If the staff member reviewing the claim sees the circumstances from a different perspective than the claimant, the staff member's perspective should be noted in writing on the form or an attachment. Example: A foster child and the biological child of the foster parent were playing in a rough manner and, as a result, the table lamp was

knocked over and destroyed. The foster parent might believe that the foster child was at fault because the foster child was older and started the rough play. The staff member might believe that both children were equally at fault. In this case, the staff member would note his or her perspective of the circumstances before signing the form.

4. The claim must be filed by the claimant, in writing using the State Institution Claim Form (Exhibit A) with the office of the Attorney General, within 120 days of the occurrence upon which the claim is based.

5. The claimant is not required to submit a claim to his or her homeowner's insurance company for primary coverage of the expenses.

6. The staff member must advise the claimant that it is improper (fraudulent) to request reimbursement from the Claims Fund and homeowner's insurance for the same claim unless one is used to supplement the other. If homeowner's insurance coverage is used, the Institutional Claims Fund may be used only to request restitution for any deductible amount and/or repair of damage the homeowner's insurance coverage did not pay. Paperwork from the homeowner's insurance must be included with the form and receipts. For example: If the damage cost $600 to repair and homeowner's insurance paid $100 due to a $500 deductible, the $500 deductible could be claimed through Claims.

7. Claims that exceed $1,000.00 for children in shelter status, and $1,500.00 for children in foster care status require state legislative approval. The staff member should assist the foster parent or other claimant in contacting his/her state legislative representative, if necessary.

8. All claims processed under this procedure must be paid by the Case Management Organization which is assigned the case.

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.

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.