

Series:	Operating Procedures	COA: CFOP: 170-16
Procedure Name:	State Institutional Claims for Damages Caused by Shelter or Foster Child	
Procedure Number:	OP1060	
Review Date:	02/23/12, 03/11/16, 06/25/2020, 04/16/24, 10/6/2025	
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Applicable to: All FPOCF Staff and Contract Providers

PURPOSE: 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 child in foster care or shelter status.

PROCEDURE:

Definitions For the purposes of this operating procedure:

State Institutions Claim Fund: A program established by the Legislature pursuant to s.402.181(1), Florida Statutes (F.S.) for the purpose of making restitution for property damages and direct medical expenses related to injuries caused by shelter or foster children.

Claimant: The person who suffered personal injury or property damage.

1. Authority

Section 402.181, F.S.; Chapter 2-6, Florida Administrative Code (authorizing the Restitution Claim Form -- see appendix A to this operating procedure).

2. General Requirements

Statutory language in s.402.181 (2), F.S. makes the following distinction necessary:

1. At the time the injury or damage occurred if the child responsible was:
 - a. In shelter legal status [pursuant to a court's shelter order], restitution up to \$1,000.00 may be claimed.
 - b. In foster care legal status [pursuant to a court order granting custody to Family Partnerships of Central Florida (FPOCF) for placement in foster care], restitution up to \$1,500.00 may be claimed.
2. 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.
 - a. When a shelter parent, foster parent or other individual advises a care manager of expenses they have incurred from personal injury or property damage caused by a shelter or foster child, the care manager will:

- i. Assist the claimant in completion of the Restitution Claim Form.
- ii. Ensure that the form is completed in its entirety and that legible receipts (or estimates) from a licensed vendor are attached.
- iii. Review the circumstances of the claim and have the claimant sign the form.
 - (a) If the care manager reviewing the circumstances does not agree that the shelter or foster child was responsible for the injury or property damage, the care manager should note that opinion on the signature line.
 - (b) If the care manager reviewing the claim sees the circumstances from a different perspective than the claimant, the care manager'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 rough play. The care manager might believe that both children were equally at fault. In this case, the care manager would note his or her perspective of the circumstances before signing the form.
- iv. Confirm the damage described in the application. This can be completed through observation of the home or by reviewing validated documentation provided by the claimant (i.e., pictures).
- v. Confirm that the claimant has provided pictures of the damage, two written estimates for repair, or receipt(s) if the repair has been paid for.
- vi. The form will be processed and sent to the Office of the Attorney General no later than 10 business days after receipt of the completed form with receipts and estimates attached.

The claim must be filed by the claimant, in writing (see end of this Operating Procedure, Restitution Claim Form), with the office of the Attorney General, within 120 days of the occurrence upon which the claim is based.

3. The claimant must provide pictures of the damage, two written estimates for repair, or receipt(s) if the repair has been paid for.
4. The claimant is not required to submit a claim to his or her homeowner's insurance company for primary coverage of the expenses.
5. The care manager must advise the claimant that it is improper (fraudulent) to request reimbursement from the Institutional 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 costs \$600 to repair and homeowner's insurance paid \$100 due to a \$500 deductible, the \$500 deductible could be claimed through Institutional Claims.

6. Claims that exceed \$1,000.00 for children in shelter status, and \$1,500.00 for children in foster care status require legislative approval. The care manager should assist the foster parent or other claimant in contacting his/her state legislative representative, if necessary. The representative can be referred to section 402.181(2), F.S. for the statutory reference to the necessary legislative approval.
7. If the claim is denied by the Office of the Attorney General, the claimant has a right to appeal pursuant to Chapter 120, F.S. The claimant must request a hearing in writing within 21 days following notification of the adverse decision pursuant to s. 120.57, F.S. The request for a hearing must be sent to the Office of the Attorney General

BY DIRECTION OF THE PRESIDENT AND
CHIEF EXECUTIVE OFFICER:



PHILIP J. SCARPELLI
President and Chief Executive Officer
Family Partnerships of Central Florida

APPROVAL DATE: 10/17/2025



STATE INSTITUTIONS CLAIMS

This document must be completed and submitted by the agency filing a claim on behalf of an individual for restitution of direct medical expenses and/or property damage up to \$1,500 caused by foster children, or direct medical expenses and/or property damage up to \$1,000 caused by shelter children, or escapees or inmates of state institutions under the Department of Children and Families, the Department of Juvenile Justice, or the Department of Corrections.

Please type or print legibly and complete all numbered items. Mail this completed document to the address shown on page 2.

1. Date of Incident
2. Name and address of the claimant (the person who suffered personal injury or property damage).

Name: _____

Address: _____

City/State/ZIP: _____

Home Telephone: _____ Work Telephone: _____

Social Security Number: _____

3. If the claimant is a child, incompetent, deceased or otherwise incapable of preparing the claim, give the following information on the person who will receive the restitution payment on behalf of the claimant:

Name:

Address:

Home Telephone:

Social Security Number:

The relationship to the claimant:

_____ Parent

_____ Estate Representative

If "Other," explain:

City/State:

Work Telephone:

ZIP

_____ Legal Guardian

_____ Other

4. Give a brief statement of the facts upon which the claimant seeks restitution for injury or damages or attach your agency incident report. Include sufficient information to establish that the person causing the injury or property damage was an inmate, escapee, patient, shelter or foster child. Include the full name(s) of the person(s) causing the injury or damage.



STATE INSTITUTIONS CLAIMS

5. Name and address of the state facility under the Department of Children and Families, Department of Juvenile Justice or Department of Corrections at which the child in custody, inmate, escapee, or patient was assigned at the time of the claimant's injury or property damages. For claims resulting from the actions of shelter or foster children, indicate the Department of Children and Families office and case worker.

Name of Facility:

Chief Administrative Officer or Case Worker (CBC Family Partnerships of Central Florida):

Address:

City/State:

ZIP

Telephone:

6. **Total amount of damages to property:** \$ (Attach itemized receipts or estimate of repair)

7. **Total amount of direct medical expenses:** \$ (Attach itemized receipts)

8. **Statement of Claimant**

By my signature, I certify that all information contained herein is accurate, based upon my direct and personal knowledge.

Signature of Claimant or Claimant's Representative

Date

9. **Statement of State Agency Representative**

I am aware of the circumstances regarding this incident, and I believe the information contained herein is accurate to the best of my knowledge.

Signature

Date

Print Name: _____

Position: _____

Telephone: _____

Mail the completed original claim form and attachments to:

Office of the Attorney General
Bureau of Victim Compensation
The Capitol, PL-01
Tallahassee, FL32399-1050

INSTRUCTIONS:

The claim must be filed in writing with the Office of the Attorney General within 120 days of the occurrence of physical injury or damage upon which the claim is based. Failure to file within the prescribed time frame will result in denial of the claim. It is the responsibility of the state agency to ensure that all information necessary to determine eligibility is provided. To protest a decision of the Office, the claimant shall request a hearing, in writing, within 60 days following the date of the claim notice, pursuant to the provisions of Section 120.57, Florida Statutes, and Chapter 28-5, Florida Administrative Code