



State Institutional Claims for Damages Recommendation Form

A. This section is to be completed by the Community-Based Care lead agency (CBC) representative upon review of the claimant's application for restitution.

Claimant Name: _____

Phone Number: _____

Email address: _____

Date CBC Representative acknowledging receipt of application: _____
(This should mirror the date on the application.)

The State Institutional Claim form for damages was submitted by the claimant listed above. The Community-Based Care representative has reviewed the claim and recommends the following:

- The attached application meets the criteria for reimbursement consideration.
- The request for reimbursement is not recommended.

Name of CBC Representative

Signature

Email address: _____

CBC Name: _____

Date: _____

B. This section is to be completed by the Office of General Counsel.

The Office of General Counsel has reviewed the claim, supporting documentation, and the recommendation from the Community-Based Care representative and has made the following determination for payment processing:

- Approved
- Denied

DCF Attorney

Signature

Email address: _____

Date: _____

Upon approval, the Regional Community-Based Care Contract Manager shall forward a copy of the State Institutional Claims for Damages Recommendation Form and the Restitution Form for payment processing to the Office of Finance and Accounting at HQW.ASSC.Contract.Invoices@myflfamilies.com.