STATE OF NEW YORK - DEPARTMENT OF CORRECTIONS AND COMMUNITY SUPERVISION

INMATE CLAIM FORM

FACILITY CLAIM # ___ – ____ – __
FAC ID# SEQ. NUM. YR.

PART1: INMATE IDENTIFICATION AND DESCRIPTION OF LOSS

1. INMATE'S NAME	2. DEPT. ID#	3. FACILITY NAME	4. CELL/BLOCK	5. DATE

6. DESCRIPTION OF LOSS (INCLUDE PARTIES INVOLVED AND OTHER PERTINENT DATA NECESSARY TO THE SETTLEMENT).

PART 2: EVALUATION SCHEDULE

ITEM NAME AND DESCRIPTION	ORIG. COST	AGE	CONDITION	DEPRECIATION	REIMBURSEMENT REQUESTED	Do not write in shaded space
1.	$			%	$	
2.	$			%	$	
3.	$			%	$	
4.	$			%	$	
5.	$			%	$	
6.	$			%	$	
7.	$			%	$	
8.	$			%	$	
9.	$			%	$	
10.	$			%	$	
BALANCE BROUGHT FORWARD FROM CONTINUATION SHEETS					$	
TOTAL					$	

Certification of Items and Values: I hereby certify that the listed personally-owned items and values are just, true and correct and that the amounts claimed herein are considered to be legal claim against the State of New York.

CLAIMANT'S SIGNATURE _____

Please refer to this number in all correspondence.

FACILITY CLAIM # ___ - ____ - __
FAC ID# SEQ. NUM. YR.

PART 3: FACILITY INITIAL REVIEW

I have personally reviewed this claim and examined damaged items (as available).

☐ REJECTED * This claim has been rejected for the following reason(s) and is being returned to the claimant.

☐ 1. Claim value not reasonable or realistic.
☐ 2. Claim items not adequately described. Give more detail.
☐ 3. Claim articles do not indicate age/condition at time of loss.
☐ 4. No depreciation for use, age or wear indicated.
☐ 5. Claim value not substantiated with copy of invoice.
☐ 6. Other (specify):_____

*This claim may be resubmitted with additional information or documentation to correct the deficiencies checked.

☐ APPROVED This claim is approved/approved in part. Claimant is offered reimbursement in the amount of $ ____

☐ DISAPPROVED This claim is disapproved for the following reason(s). Claimant may appeal (see Part 4).

☐ 1. Evidence indicates that the claimant is substantially responsible for the loss or damage.
☐ 2. Evidence indicates that the facility was not at fault or in any way responsible for the loss or damage.
☐ 3. The evidence does not indicate that the claimant owned or possessed the article(s) in question.
☐ 4. Other (specify): _____

Explanation: _____

NAME/TITLE _____ SIGNATURE _____ DATE _____

PART 4: APPEAL

If dissatisfied with the initial review, the claimant may appeal by completing this section and forwarding this form to the Superintendent.

Statement (optional): _____

CLAIMANT SIGNATURE _____ DATE _____

PART 5: APPEAL REVIEW

Superintendent (up to $500)/ Div. of Budget and Finance, Office of Inmate Accounts (over $500)

☐ APPROVED In the amount of $ ____

☐ DISAPPROVED A claim may be filed in the NYS Court of Claims. Your claim must be filed and served within 120 days of the date of this final determination, as required by law.

COMMENTS: _____

NAME _____ Supt./ Div. of Budget & Finance / Inmate Accts. SIGNATURE _____ DATE _____