Consumer and Worker Protection

HOME IMPROVEMENT CONTRACTOR TRUST FUND SUPPLEMENTAL CLAIM FORM

As of July 18, 2025, the maximum reimbursement amount for approved Claims under the Home Improvement Contractor Trust Fund Claim Process is **$20,000**, an increase from $10,000.

Use this form to claim additional reimbursement if you previously submitted a Claim and were approved for $10,000.

Please complete this form which must be notarized by a Notary Public and submit any documentation of additional reimbursable costs beyond those in your original approved Claim.

CLAIMANT INFORMATION

Last Name	Suffix *(Jr., Sr., Esq.)* (Optional)	First Name	Middle Name (Optional)	
Date of Birth (YYYY-MM-DD) ☐☐☐☐-☐☐-☐☐				
Home Address *(Building Number, Street Name, Apartment/Suite/Other)*				
City	State	ZIP Code	Country/Region *(if outside USA)*	
Phone 1 (Primary) ( )		Phone 2 (Alternate) ( )		
Email (By providing your email address, you consent to receive communications electronically from DCWP, and you affirm that the email listed is a reliable form of communication for you.)				

SUPPLEMENTAL CLAIM INFORMATION

Approved Original Claim Amount:	$
Supplemental Claim Amount: *(amount in addition to prior approved Claim Amount)*	$
Total Amount: *(sum of original Claim and Supplemental Claim can't exceed $20,000)*	$

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ORIGINAL AND SUPPLEMENTAL CLAIM ITEMIZATION

List all invoices and/or estimates submitted with your original and Supplemental Claim.

Business Name	**Invoice/Estimate Date**	**Invoice/Estimate Cost**	**Provided with Original Claim?**	
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
		$	☐ Yes	☐ No
Total Amount: *(amount should match prior section)*		**$**		

ADDITIONAL COMMENTS

If you feel that you need to provide more information to support your Supplemental Claim, please use the space below.

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AFFIRMATION – Please read and sign below.

I am authorized to complete and submit this Supplemental Claim Form and all attachments (together, the "Supplemental Claim"). I have reviewed the entire Supplemental Claim. I affirm that the contents of this Supplemental Claim are true, correct, and complete.

If any of the information in this Supplemental Claim changes, I will inform the Department of Consumer and Worker Protection of those changes.

I understand that the Department of Consumer and Worker Protection has not yet considered this Supplemental Claim.

This Affirmation shall be deemed executed in the City and State of New York and shall be governed by and construed in accordance with the laws of the State of New York (notwithstanding New York choice of law or conflict of law principles) and the laws of the United States.

I affirm that these statements are true and correct.

____
Print Full Name

___________________________________ _______________________________
Claimant Signature Date

State of ______________________)

)ss.:

County of ______________________)

On the _______ day of _____________ in the year __________, before me, the undersigned notary public, personally appeared _______________________________, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name(s) is (are) subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

____
Notary Public