

STATE OF NORTH CAROLINA

_____ COUNTY

SPECIAL CHILDREN ADOPTION INCENTIVE FUND

VERIFICATION OF CHILD'S NEED FOR DAILY SUPERVISION

I certify that I am a licensed health, mental health or developmental disability practitioner directly involved in the care of _____.
Name of Child

This child has a health condition which requires *eight or more hours* of daily direct supervision from a foster parent, health professional and/or special education teacher to meet personal health needs or prevent self-destructive or assualtive behavior. The child's daily supervision needs include the following:

Signature

Position/Title

Date