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

DSS-5213 (Revised August 2003)
Family Support and Child Welfare Services