

STATEMENT OF EXCEPTIONAL NEEDS

<p>PART I – To be completed by the authorized agency representative and the child 's parent or guardian.</p> <p>By signing this form and for the purpose of verifying my child 's exceptional need as it relates to my family 's eligibility for subsidized child care and development services, I authorize and request the health professional named in Part II to release the information requested to the agency identified below. I further authorize the health professional to discuss any information on this form with the agency in order for the agency to verify, clarify, or complete it. I understand the health professional may also require that I complete his or her own release form prior to providing the information requested below.</p>				
NAME OF PARENT/CARETAKER		SIGNATURE OF PARENT/CARETAKER		DATE
NAME AND AGE OF CHILD FOR WHOM FINANCIAL ASSISTANCE FOR CHILD CARE IS BEING REQUESTED:				
AGENCY 4C Council of Santa Clara County, Inc.		AUTHORIZED AGENCY REPRESENTATIVE		TELEPHONE NUMBER (408) 487-0747
ADDRESS 2515 North First Street		CITY San Jose	STATE CA	ZIP CODE 95131

<p>PART II – To be completed by the licensed health professional.</p> <p>For the family to be eligible to receive child care and development services for the above named child, the California law requires verification, at least annually, of the exceptional need of the child that requires special attention of adults in a child care setting when the parent or guardian cannot provide the care himself/herself. (See California Code of Regulations, Title 5, §18089.) Your cooperation in completing and returning this form to the agency listed above within 15 days of receipt is requested.</p>				
<p>I certify that _____ has exceptional needs that require the special attention of adults in a child care setting when his/her parent or legal guardian cannot provide the care himself/herself. Circle one:            YES            NO</p> <p>Comments, if applicable:</p>				

Please sign and submit this form to the agency listed in Part I within 15 days of receipt of this form.

NAME OF LICENSED HEALTH PROFESSIONAL		LICENSE NUMBER		
SIGNATURE OF LICENSED HEALTH PROFESSIONAL		DATE	TELEPHONE NUMBER (    )	
ADDRESS		CITY	STATE	ZIP CODE