



Kauai Enhancements Program Referral Form

Please type or print legibly. One form needed per child. Do not leave any questions blank.

Name of Professional or Resource Parent making the referral: _____

Agency: _____ Program/Unit: _____

Phone: _____ Email: _____

Supervisor Signature (DHS): _____

Child's Last Name: _____ Child's First Name: _____

Gender: M F DOB: _____ Primary Ethnicity: _____

Name of town or city the child currently lives in: _____

Select the child's current placement: (check one)

- Biological Parent/s Adoption Legal Guardianship Permanent Custody
 Foster Care Kinship (grandparents or other relatives) Other

Select the household's annual income level: (check one)

- \$16,930 or less \$16,931 - \$25,710 \$25,711 - \$34,490 # of persons in household: _____
 \$34,391 - \$50,720 over \$50,721

Select the type of abuse the child has experienced: (check all that apply)

- Sexual Abuse Physical Abuse Severe Emotional Abuse Severe Neglect
 Victim of Abuse Resides/ed in a Household During Abuse

Briefly describe the abuse and explain how the fulfillment of this request will contribute to the child's healing process.

Use additional paper if necessary:

I hereby grant permission to the _____ (referring agency) to release information to The Children's Alliance of Hawaii (CAH) to service the request for the above named child. CAH will use the confidential information solely for the purpose of financial tracking and to collect data for statistical purposes. I hereby certify that this information is accurate and no duplicate request has been made to any other agency or organization for this request.

Signature: _____ Date: _____

Child's Last Name: _____ Child's First Name: _____

Name of Person Making the Referral: _____ Phone: _____

Describe the item, activity or service you are requesting funding for:

What is the total amount you are requesting? \$ _____

Make Check Payable To: _____

Address: _____ City: _____ Zip Code: _____ Phone: _____

Mail Check To: _____

Address: _____ City: _____ Zip Code: _____ Phone: _____

Full name of person who will be authorized to use the check at the store? (name of foster parent, caseworker, etc.):

Do you know of other resources to fund this request? What resources have you tried? What was the outcome? _____

Is this a first request for this child? If no, has anything changed in the child's life since last request (name, placement, abuse)? _____

Please fax this form to Cristine Reeves at 246-3734 or email to reeves@cahawaii.org. For questions call 246-3736 x202.

The intention of CAH is to provide the quickest service possible. However, please allow 5-7 business days for the process and completion of this request. You will be contacted by phone or email with the request status or if additional information is needed.

Please note CAH checks will void after 60 days. To avoid a \$25 cancellation fee, please return any unused checks to CAH.

A copy of the receipt after purchase is required by CAH. A self-addressed stamped envelope is provided with each check. Future requests may not be approved until a copy of the receipt is submitted.

Thank you letters or cards in the child's handwriting are appreciated.



CAH USE ONLY: File #: _____		Account Category: _____
<input type="checkbox"/> Funded	<input type="checkbox"/> Not Funded – Reason: _____	
<input type="checkbox"/> Hughes Kauai	FABR \$ _____	FAA \$ _____
<input type="checkbox"/> Geist Kauai	FABR \$ _____	FAA \$ _____