# Oahu 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: ______________________________

**Child's Last Name: ______________________________ Child's First Name: ______________________________**

Gender: ☐ M ☐ F DOB: ____________________ Primary Ethnicity: ______________________________

Name of city the child currently lives in (if in Honolulu, please include zip code): ______________________________

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 ☐ $34,391 - $50,720 ☐ over $50,721

# of persons in household: ____________________

Select the child's sexual abuse history: (check one)

☐ 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:** ________________

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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 599-5909 or email to reeves@cahawaii.org. For questions call 599-2955 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: _________

☐ Funded ☐ Not Funded – Reason: __________________________________________________

☐ Hughes Oahu FABR $ _________ FAA $ _________

☐ Geist Oahu FABR $ _________ FAA $ _________