



The Children's Alliance of Hawai'i, Inc.

Oahu Enhancements Request Form

Please type or print legibly. One form needed per request per child.

Name of Professional making the referral: _____

Agency: _____ Program/Unit: _____

Address: _____ Phone: _____ Email: _____

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

Gender Identity: _____ Birthdate: _____ Primary Ethnicity: _____

Child's Address: _____ 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)

- \$26,460 or less
- \$26,461 - \$35,700
- \$35,701 - \$44,940
- \$44,941 - \$54,180
- over \$54,181

of persons in household: _____

Select the child's abuse history:

(Check all that apply)

- Sexual Abuse:
- Physical Abuse
- Neglect
- Victim of abuse
- Resided in household during abuse

If available, please attach a current sexual abuse history with request form:

- Yes, history is attached
- None available

OR Briefly describe the abuse:

I hereby grant permission to the _____ (referring agency) to release information to The Children's Alliance of Hawai'i, Inc. (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 of Parent or Legal Guardian: _____ Date: _____

Please describe and estimate the cost for the item, activity or service for which you are requesting funding:

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

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

Make Check Payable To: _____

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

Mail Check To: _____

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

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

What other resources have you tried to fill this request? 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, etc.)

Please fax this form to the Enhancements Coordinator at 599-5909. For questions, email to enhancements@childrensalliancehawaii.org or 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 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 greatly appreciated and help us in securing future funding.

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