

The FRIENDS of the Children's Justice Center of Oahu
Ho'ōla Nā Mana'ō

HOPE AND HEALING PROJECT

PHONE: (808) 445-1873 FAX: (808)595-6978

NEEDS REQUEST FORM

One Form Per Child Required – Must be completed by referring professional

Today's Date: _____

Date request needed by: _____

Child's Last Name First Name M.I.
Name: _____, _____ M F DOB: _____ AGE: _____

Ethnicity: _____ Child's current area of residence: _____

Professional
Requesting funds (Last, First): _____ E-mail: _____

Agency Name: _____ Contact Phone Number: _____

Child's History:

- Sexual Abuse
- Physical Abuse
- Sex Trafficking
- Severe Emotional Abuse
- Witness to Crime
- Other: _____

Placement (Please Check One and Describe):

- Biological Parents (both)
 - Biological Mother (single parent)
 - Biological Father (single parent)
 - Foster Care
 - Therapeutic, kinship, guardianship, permanent custody,
or adoptive families
 - Family Reunification
- Please Describe: _____

Income (Required):

- Level I \$0 - \$15,000
- Level II \$15,001 - \$30,000
- Level III \$30,001 - \$50,000
- Level IV \$50,000+

What are you requesting and how will the fulfillment of this request directly benefit the child and their healing?

How much will it cost (including tax)? \$ _____ If a check is needed, exact name of vendor: _____

Have you applied elsewhere for the funds: Yes No If yes, where from?: _____

Was it funded? Yes No

Has child been seen at the CJC? Yes No If no, why was child not seen at CJC? _____

*** Professionals: Please do not forward our contact information to your clients as we are unable to handle their calls.***

****THANK YOU LETTERS, especially from children in their own handwriting, are appreciated!****

Friends of CJC use only:

Not funded Reason: _____

Funded \$ _____ Check #: _____ Date: _____

Assistance Category: _____ Check Payable to: _____

Prior funding this calendar year: Yes No If yes, funding amount: \$ _____

Notes: _____