Guidelines for Making a Referral to Dream Imua

Only professionals working with children in Maui County can refer from their caseload.

When children experience a crisis of *any* kind, they can lose hope. Sometimes their sense of stability is shattered, their faith in the future and themselves is gone.

Our program empowers children in crisis to dream, and remind everyone that each child is someone special. Dream Imua provides dreams to children in crisis of any nature—whether they have undergone abuse, neglect, homelessness, medical problems, psychological issues, family difficulties, or experienced personal loss. We give children hope by showing them there are people who care.

All children must…

- be 4-16 years of age
- be a full-time resident of Maui County
- not have previously received a dream
- be appropriately referred by a service professional working in Maui County
- have an adult available to be a chaperone during their Dream Day or consent to Dream Imua providing a chaperone.

Follow these steps in order to refer a child to the Dream Imua program:

1. Complete the referral form and have the parent fill out the consent form.
2. Be sure the child has a willing chaperone available to participate in the Dream
3. Do not share the program with the child until the child has been accepted by Dream Imua
4. Remember not every child has the support to receive a dream
5. Do not make any promises to the child unless directed by Dream Imua
6. All Dreams are directed by the child based on their choices and interests. Dreams must be safe activities that you can legally do on Maui.
7. Forms may be emailed or faxed or sent via mail.

For more information or to submit your referral and consent forms please contact:

Rainelle Lushina at 808-244-7467 or fax to 808-242-5835 dream@imuafamilyservices.org

Professional Care Provider Referral Form

Child's Name_____Birthdate_____Sex_____

Parent/Legal Guardian _____ Phone _(____)_____

Email_____

Address_____

Please explain in detail the crisis the child is facing in the space below:

Person making referral:_____Phone (_____)_____

Agency/Program:_____

Email_____

Address_____

Do you wish to participate in the Child's Interview? ☐ Yes ☐ No

Comments/Suggestions:

Guardian Consent for Referral

Child's Name _____Birthdate _____ Gender _____

Parent/Legal Guardian _____Phone _(____)_____

Email _____

Address _____

I, _____, give my permission for _____, to be referred to Dream Imua, a program of Imua Family Services. I understand that this consent gives the staff of Dream Imua permission to obtain information concerning my child from other service providers. This information will be kept confidential and will only be used to ensure that the program is responsive to the needs of the child.

Please indicate these providers below:

Name _____ Phone _(____)_____

Agency_____

Name _____ Phone (_____)_____

Agency_____

Name _____ Phone (_____)_____

Agency_____

This consent will remain in effect for the duration of my family's affiliation with the Dream Imua Program; unless a written request to revoke this permission is submitted by the named guardian above.

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Witness Date