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 and 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.

Program requirements:

- Referred 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, and
- have an adult available to be a chaperone during their Dream Day, or consent to Dream Imua providing a chaperone.

Follow these steps 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 may be legally done on Maui.
7. Forms may be emailed, faxed, sent via mail – contact info is below.

For more information, or to submit your referral and consent forms, contact us at:
phone 808-244-7467 ● fax 808-242-5835 ● dream@discoverimua.com

Professional Care Provider Referral Form

Child's Name: _____ Birthdate: _____ Sex: ____

Parent/Legal Guardian: _____ Phone: _____

Parent Email: _____

Parent 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: _____ Sex: ____

Parent/Legal Guardian: _____ Phone: _____

Parent Email: _____

Parent 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 Imua Family Services 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:

Contact Name: _____ Phone: _____

Agency: _____

Contact Name: _____ Phone: _____

Agency: _____

Contact Name: _____ Phone: _____

Agency: _____

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

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Witness Date