



REQUEST FOR SERVICES FORM (to be completed by parents and any referral sources)

Date: _____
Referral Source: _____
Phone Number: _____
Referral Sources Relationship to Child Victim: _____

Name of Child Victim: _____ **DOB/Age:** _____
Legal Guardian of Child: _____
Address: _____
Phone Number: _____

Does the child reside with Legal Guardian? YES NO
If no, please provide the following information on the Child’s current caregiver and residence.
Name of Caregiver: _____
Relationship to Child: _____
Address: _____
County of Residence: _____
Phone Number: _____

- Eligibility Requirements** (Read the following program requirements to ensure Child’s eligibility for CHP)
- Child is between the ages of 4 - 18 years old and currently resides in Columbus, Bladen, Pender, or Robeson counties.
 - Child has been a victim of crime and/or witnessed criminal acts and would benefit from mental health treatment.
 - Crimes has been reported to law enforcement and/or Department of Social Services
 - Child is able to function in a home setting (biological/relative/foster/group home)
 - Caregiver is willing to participate in the Child’s treatment while receiving services in the C.R.E.A.T.E. Hope Program.

After completing the form, please send it via fax or email to our CHP Program Director, Chante’ Clark.
Fax (910-356-0081) Email (chante.clark@bghnc.org) Phone (910)-646-3083 ext 232

***CHP Staff will contact referral source/legal guardian within 2 business day of C.R.E.A.T.E Hope Program receipt of form in order to gather additional information needed for the referral process. Thank you!**

*** This portion is to be completed by C.R.E.A.T.E Hope Program Staff**

Date Received by CHP Staff: _____ **Referral Received by:** email fax face to face

Date of CHP Staff Returned Contact: _____
Status of Contact: Referral Completed
 Voicemail Left
 Voicemail Full
 Second Contact Date: _____