Coastal Horizons
Promoting Choices for Healthier Lives and Safer Communities

Internal Use Only:
Received By:_____On:_____
Date Contacted Referral Source: _____
Date Contacted Family: _____

SAMHSA School Aged Disaster Grant Referral Form

There are four components offered through this program:
Community Training, Health/Wellness Services, Family Youth Partner, Mental Health Treatment.
Please complete the form below for all services that are being requested.
Fax Referral Form to (910) 790-9945

Contact Information for Individual Requesting Services or Referral Source:
Name:_____Contact Number:_____

Community Training

Which training(s) you are interested in receiving:

- ☐ Community Resiliency Model®
- ☐ Reconnect for Resiliency®
- ☐ Youth Mental Health First Aid™

Health/Wellness Services

Which service(s) you are interested in receiving:

- ☐ Mindfulness Training for Parents and Teachers
- ☐ Mindfulness Training for Student
- ☐ Smoking Cessation

Who will be receiving service(s):

- ☐ Teaching/School Staff
- ☐ School aged children
- ☐ Community Members

Famiy Youth Partner

Child's Name:_____Date of Birth:_____
School: _____Grade: _____
Legal Guardian Name(s) _____
Best Contact Number(s): _____
Address (Street, City, Zip) _____
Family needs support in the following areas:

- ☐ Housing
- ☐ Supportive Guidance
- ☐ Finances
- ☐ Peer Support Group
- ☐ Navigating Systems (DSS,DJJ,School, etc)
- ☐ Child and Family Team Meetings
- ☐ Advocating in School System
- ☐ With Appointment Follow Through
- ☐ Understanding Child's Behavioral Needs
- ☐ Additional Parenting Skills
- ☐ Outside Referrals

Mental Health Treatment

Child's Name:_____Date of Birth:_____
Insurance Type: _____ Insurance # _____
Legal Guardian Name(s) _____
Best Contact Number(s): _____
Address (Street, City, Zip) _____

Please include additional information for our grant team to know: