

SCHUYLER COUNTY YOUTH BUREAU

Differential Response Referral Form

323 Owego St., Unit 6
Montour Falls, NY 14865
Phone: (607) 535-6236

JoAnn S. Fratarcangelo,
Director

Adam Lawton
Program Coordinator

REFERRAL INFORMATION

Referral Date: ____/____/____ Date of Infraction: ____/____/____ CASE # _____

Person Making Referral:

Name: _____ Contact Number: _____

Address: _____

City: _____ NY zip: _____

Parent/Guardian School _____ Agency _____
Abbreviated Name of agency

Youth Being Referred:

Name: _____ Age: _____

Address: _____

City: _____ NY zip: _____

Contact Number: _____ School attending: _____

Parent/Guardian's Name: _____

Contact Numbers: _____

****The Differential Response Program is a voluntary program. All participating parties must be in agreeance at the time of referral.****

INFRACTION: _____

(Use back of sheet if needed)

Youth's Signature: _____

Parent/Guardian's Signature: _____

****PLEASE ATTACH ANY INFORMATION THAT WILL ASSIST THE COURT IN THEIR DECISION****

THIS SECTION TO BE FILLED OUT BY THE COURT

Hearing Date: ____/____/____ Date Heard: ____/____/____ (if not same) WHY? _____

PARENT

ACCEPTED REFUSED

DATE ____/____/____

Apology Letter to Guardian

Apology Letter to Victim

Essay

Community Service

Classes

Other _____

DATE TO BE COMPLETED

____/____/____