RIYS Referral

Restorative Integrated Youth Services

Complete all sections below and fax to Oneida County Department of Family and Community Services for Supervisor Approval Scan to:
kathryn.remis@dfa.state.ny.us or nicole.genovese@dfa.state.ny.us
Questions regarding RIYS Program call 1-800- 860-1350

DEMOGRAPHICS

Date of Referral:	**Date of Birth:**	**Case ID #:**	**CIN # (required) :**
Child's Name (Last, First, MI.):			
Child's Current Address:			**City:**
Zip Code:	**County:**		**Telephone:**
Primary Language:	**Ethnicity:**		**Gender:** **Preferred Pronoun**

FAMILY DEMOGRAPHICS

Who has custody, if other than the parent?		
Parent/Guardian's Name (Last, First, MI.)	**Same Residence as Child** □ **Yes** □ **No**	
Address		**City:**
Zip Code:	**County:**	**Telephone:**
Parent/Guardian's Name (Last, First, MI.)	**Same Residence as Child** □ **Yes** □ **No**	
Address:		**City:**
Zip Code:	**County:**	**Telephone:**

Siblings and/or additional family members within the household:

Names:	Relationship to Member:	Date of Birth:

EDUCATION

School District:	**School Building:**	**Grade**	**IEP:** □ **Yes** □**No** □**Unknown**

SERVICE PROVIDERS (current)

Primary Care:	**Mental Health:**	**Substance Use:**
Other Service Providers:		

LEGAL STATUS

Pending PINS/JD □ **Yes** □ **No**	**Pre- PINS** □ **Yes** □ **No**	**PINS** □ **Yes** □ **No**	**Probation** □ **Yes** □ **No**

JD □ **Yes** □ **No**	**Adjudicated** □ **Yes** □ **No**	**N-Docket** □ **Yes** □ **No**
Court Order in Place □ **Yes** □**No** **If yes, describe:**		**Expiration Date of Court Order:**
Judge:		**Attorney for the Child:**
Docket #:	**File #:**	**Next Court Date:**

HISTORY OF PLACEMENT/SERVICES

History of Residential Placement:	☐ **Yes**	☐ **No**	☐ **Unknown**
Other:			

PRESENTING BEHAVIORS/REASON FOR REFERRAL

Current Medication Prescribed/Dosage

REFERRAL SOURCE:

Name:	**Title:**	**Organization:**
Phone:	**Email**	
Supervisor Signature:	**Title:**	

OTHER APPLICABLE INFORMATION:

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OCDFCS USE ONLY

OCDFCS APPROVAL

Once approval is completed, Fax to the CNYHHN Referral Department # (315) 624-9428

Supervisor Signature:	**Title:**
Date of DFCS Approval:	**Date Assigned to RIYS:**