NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUIRED FORMS AND CLEARANCE LIST

CHILD CARE PROGRAMS

The following individual forms listed must be completed for all staff, legally-exempt providers, volunteers and all household members 18 years of age or older as noted in the chart below:

- **DCC, SACC and Legally-Exempt Group Program Staff and Volunteers:** Submit all required forms listed below to your Director. Director or designee enters the information from the **LDSS-3370** form into the Online Clearance System (OCS). If payment is not made with credit card, the $25.00 payment, in the form of certified check or money order, must be mailed to appropriate licensing/registration office. Your clearances will **NOT** be processed without payment. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. All clearance documents are then submitted to the Licensor/Registrar or Enrollment Agency. Director checks references and qualifications for DCC and SACC staff/volunteers.
- **DCC, SACC and Legally-Exempt Group Program Directors:** Submit all required forms listed below to your Licensor/Registrar or Enrollment Agency along with SCR payment. Your clearances will **NOT** be processed without payment. Schedule an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. All clearance documents are then submitted to the Licensor/Registrar or Enrollment Agency.
- **All GFDC/FDC/SDCC Staff and Household Members:** Submit all required forms listed below to your Licensor/Registrar. Your clearances will **NOT** be processed without payment. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment (if noted below).
- **Legally-Exempt Informal Child Care Providers*, Staff and LE Family Child Care Household Members 18 and older**:** Submit all required forms listed below to your Enrollment Agency. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. Your clearances will **NOT** be processed without payment

*Legally-exempt informal child care providers who are related to ALL children in care as a grandparent, great grandparent, sibling (who resides in a separate residence), aunt or uncle are exempt from comprehensive background check requirements, as are their staff and volunteers.

**Legally-exempt family child care household members age 18 or older who are related to ALL children in care in any way are exempt from comprehensive background check requirements.

Requirement	All Staff & Volunteers in licensed/ registered programs	G/FDC Household Member 18 Years & Older	G/FDC Household Member Under 18 years old	Legally-Exempt Group Staff and Volunteers	Legally-Exempt Informal Providers, Staff, Volunteers and LE Child Care Household Members 18 years & older
LDSS-3370 *Statewide Central Register Database Check (includes the form and instructions for completing the DCCS version)*	X	X		X	X
OCFS-4930 *Request for Fingerprinting Services-Child Care*	X	X		X	X
OCFS-6001 *Child Care Provider, Staff, Volunteer, and Household Member Information*	X	X	X	X	X
OCFS-6002 *Qualifications*	X				
OCFS-6003 *References*	X				
OCFS-6004 *Child Care Provider, Staff, Volunteer, and Household Member Medical Statement*	X	X	X	X	
OCFS-6005 *Criminal Conviction Statement*	X	X			
OCFS-6022 *Request for Staff Exclusion List Check*	X	X		X	X

OCFS-6000 (Revised 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUIRED FORMS AND CLEARANCE LIST

CHILD CARE PROGRAMS

The requirements for the comprehensive background checks will be completed using these forms. OCFS will provide written notice as to whether or not the individual is authorized to care for children once the process is complete.

New York State Criminal History Record Check (form OCFS-4930) *NYS Department of Criminal Justice Services*
National Criminal Record Check (form OCFS-4930) *Federal Bureau of Investigation*
New York State Sex Offender Registry Search (form OCFS-6001) *NYS Department of Criminal Justice Services*
***National Sex Offender Registry Search (form OCFS-4930)** *National Crime and Information Center*
Statewide Central Register Database Check (form LDSS-3370) *SCR of Child Abuse and Maltreatment*
Staff Exclusion List Check (form OCFS-6022) *New York State Justice Center*
State Sex Offender Registry, Child Abuse or Maltreatment, and Criminal History Repository Search (form OCFS-6001) *In each state other than New York where you have lived in the last 5 years*

***required in accordance with a schedule that will be released by the office at a later date**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE PROVIDER, STAFF, VOLUNTEER AND HOUSEHOLD MEMBER INFORMATION

Child Day Care Programs

Instructions:

- Please **PRINT** clearly. This form **MUST** be completed by every individual identified on form **OCFS-6000**.
- If you are not sure which role to choose, refer to the child day care regulations and/or consult with your licensor, registrar, or legally-exempt enrollment agent.

PROGRAM NAME:	FACILITY ID NUMBER:
DATE: / /	

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care, Small Day Care Centers, Legally-Exempt Informal**	**Day Care Center, School-Age Child Care, Legally-Exempt Group**	**All Programs**
ROLE:	☐ Provider ☐ Substitute (GFDC/FDC) ☐ Assistant (GFDC/FDC) ☐ Household Member	☐ Director ☐ Group Teacher (DCC/SACC) ☐ Assistant Teacher (DCC/SACC) ☐ Teacher (LE GROUP)	☐ Volunteer ☐ Employee

Personal Information

NAME *(First, MI, Last):*		
ADDRESS:	APT:	FLOOR:
CITY:	STATE:	ZIP:
PHONE:	E-MAIL:	
	DATE OF BIRTH (mm/dd/yyyy): / /	

Have you ever been known by any other name? ☐ Yes ☐ No

If Yes, list all known names (including maiden name, aliases, pseudonyms)

Have you ever lived outside of New York State in the past five years? ☐ Yes ☐ No

If Yes, complete page 2 of this form and enter all out of state addresses where you lived in the past five years.

If No, you do not have to complete page 2.

Applicant's Name: ______________________________

Out of state addresses (Previous five years)

Print clearly. <u>All</u> dates must be consecutive *(month/year)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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OCFS- 6002 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

QUALIFICATIONS

Child Day Care Programs

PROGRAM NAME:	FACILITY ID NUMBER:
NAME OF PERSON WITH PENDING ROLE:	DATE OF BIRTH (mm/dd/yyyy): / /

The New York State Office of Children and Family Services (OCFS) child day care regulations identify qualifications and minimum requirements for caregiving staff in child day care programs. The information is included in section **.13** of the regulations. Regulations can be obtained at ocfs.ny.gov/main/childcare/default.asp and from your licensor/registrar.

Instructions:

- Consult OCFS regulations for qualification and minimum requirements for your role.
- Complete sections that apply to your role in the program. You may attach a resume.
- You may be asked to submit additional documentation to demonstrate education, training, or child care experience.
- Please **PRINT** clearly

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care and Small Day Care Centers**	**Day Care Center and School-Age Child Care**
ROLE IN PROGRAM	☐ Provider ☐ Volunteer ☐ Assistant ☐ Substitute	☐ Director ☐ Volunteer ☐ Group Teacher ☐ Assistant Teacher

Education/Training (if applicable for pending role)

Date Range	**Degree, Major, Name of Credential, or Training**	**Institution**	**Number of Credits** (if applicable)

Child Care Experience

Date Range	**Description**	**Location**	**Age of Children**

Supervisory Experience (applicable for pending role of Director at Day Care Center/School-Age Child Care program)

Date Range	**Description**	**Location**

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REFERENCES

Child Day Care Program

Instructions:

- Please provide complete information for two people (one employment reference and one personal reference) we can contact.
- Relatives may **NOT** be used as references
- If you have been employed outside the home, please include an employer as one of your references
- Please **PRINT** clearly

PROGRAM NAME:	FACILITY ID NUMBER:
NAME:	

TYPE OF PROGRAM	**Family Day Care, Group Family Day Care and Small Day Care Centers**	**Day Care Center and School-Age Child Care**
ROLE IN PROGRAM	☐ Provider ☐ Assistant ☐ Substitute	☐ Director ☐ Teacher ☐ Volunteer

REFERENCE #1 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

REFERENCE #2 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

REFERENCE #3 (Optional)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
- Only a health care provider (physician, physician assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.

Program's Name:	Facility ID Number:
Person's Name:	Date of Birth: / /

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care, Small Day Care Centers**	**Day Care Center, School-Age Child Care, Legally-Exempt Group Programs**	**All Programs**
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Group Teacher ☐ Assistant Teacher	☐ Employee ☐ Volunteer

Typical child day care duties

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

Following to be completed by health care provider ONLY

Medical status

To the best of my knowledge of the above-named individual, I find that:			
They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a physical condition that would prevent them from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ NA *(if only role is volunteer or household member)*
For any "YES" responses, clarify and/or indicate restrictions:			

Signature *(physician, physician's assistant, nurse practitioner)*

Title

Name *(please PRINT clearly or use office stamp)*

Date of Exam / /

( ) -
Phone

Date of Signature / /

*(**Continued on reverse side**)*

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Program's Name:	Facility ID Number:
Person's Name:	Date of Birth:

Instructions:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page. No one with a role in a legally-exempt program needs to complete the turberculin test.
- A health care professional (physician, physician's assistant, nurse practitioner) *or a registered nurse as part of his/her duties at a health care facility*, may enter the results in the tuberculin test Information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please **PRINT** clearly.

Following to be completed by health care professional ONLY

Tuberculin test information

Test completed

Test read on: ____/____/____
(mm / dd / yyyy)

Test result: ☐ Positive ☐ Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Test not completed

☐ Not tested. Provide reason: _____

_____
Medical Exemption or Contraindication

If test result was previously positive, indicate date: ____/____/____
(mm / dd / yyyy)

If previously positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

_____
Signature *(physician, physician's assistant, nurse practitioner or registered nurse)*

_____ _____
Name *(please PRINT clearly or use office stamp)* Title

( ) - ____/____/____
Phone Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs**–return this completed form to your licensor or registrar.
- **DCC/SACC programs-directors**–return this completed form to your licensor or registrar; all other staff–return the form to the director for evaluation.
- **Directors of legally-exempt group programs**–return this form to your enrollment agency.
- **Employees and volunteers at legally exempt programs**–return this form to your director

OCFS-6005 (9//2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CRIMINAL CONVICTION STATEMENT

CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- **ALL** applicants for a licensure or registration, staff, volunteers, and household members 18 years of age or older must complete and sign this Criminal Conviction Statement.
- Please **PRINT** clearly

PROGRAM NAME:	FACILITY ID NUMBER:
PERSON'S NAME:	DATE OF BIRTH *(mm/dd/yyyy):*

CERTIFICATION

I certify that to the best of my knowledge and belief:

☐ **I HAVE** ☐ **I HAVE NOT** **been convicted of a crime in New York State or other jurisdiction.**

(A crime is a misdemeanor or felony only; this does not include violations. You do not need to disclose crimes that the court designated with a "Youthful Offender" status.)

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license or registration to provide child care at this site.

SIGNATURE: _____ DATE: *(mm/dd/yyyy):* ___/___/_____

OCFS-6022 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUEST FOR STAFF EXCLUSION LIST CHECK

Child Day Care Programs

PROGRAM NAME:	FACILITY ID NUMBER:

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked as part of the comprehensive background check process for the individuals identified below and on the **OCFS-6000** form.

Instructions:

- This form is used to check the Justice Center's (SEL).

To determine where to submit this form, find the type of program and the individual's position in the list below.

Type of program / Role in the program	Where to submit
Family Day Care, Group Family Day Care and Small Day Care Center (Staff, Volunteers, and Household Members Age 18 and older)	The licensor/registrar of the program
Day Care Center and School-Age Child Care (Directors)	The licensor/registrar of the program
Day Care Center, Legally-Exempt Group Program and School-Age Child Care (Staff and Volunteers)	The director of the program
Legally-Exempt Group Program Directors, Legally-Exempt Informal Child Care (Providers, Staff, Volunteers, and Household Members Age 18 and older)	The Enrollment Agency of the program

If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information below. Please **PRINT** clearly to avoid delays in processing.

First name: _____

Last name: _____

Middle initial:

Social security number: ___ - ___ - _____

Date of birth *Only if no social security number or alien registration number is available:* ___ / ___ / _____

Alien registration number *Only if no social security number is available*: _____

Position applied for: _____

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUEST FOR NYS FINGERPRINTING SERVICES
Child Care Programs

Enrollment Information:

Applicant must have an appointment to be fingerprinted. At the appointment, the applicant will need to bring this form and acceptable ID.

Appointments can be made by contacting the vendor at one of the following:
Website: https://uenroll.identogo.com/workflows/15441V or the **Call Center**: **877-472-6915**

Contributor Agency Section:

Service Code: **15441V** Contributor Agency: **NYS Office of Children and Family Services-Child Day Care Programs**

Facility/Agency ID Number: _____

Facility Name/Address: _____

Fingerprint Applicant Section: ☐ New Submission ☐ Resubmission

Name of Applicant: _____

Alias / Maiden Name: _____

Street Address: _____

City, State, & Zip: _____

Date of Birth: **/ /** _____ Sex: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

☐ Other ☐ Unknown

Skin Tone: _____ Eye Color: _____ Hair Color: _____

Height: _____ ft. _____ in. Weight: _____ lbs.

State/Country of Birth: _____

Role of Fingerprint Applicant (please check one):

CHILD CARE: ☐ Director (D) ☐ Provider (F) ☐ Employee/Teacher (T) ☐ Volunteer (V)
☐ Household Member over the age of 18 (HM)

Fingerprint Applicant Affirmation Section

I hereby affirm that the information contained in the application and the supporting documents are true and do not contain any false statements or omissions of any material information or facts. I understand that the making of false written statements in this application is punishable as a class A misdemeanor under Section 175.30 and/or Section 210.45 of the New York Penal Law.

Applicant's signature: **X**	Date: / /

Payment Section:

Agency Billing Account

Accepted Forms of Identification to bring to your appointment (must be valid and not expired):

- Driver license issued by a state or outlying possession of the United States, U.S.
- Driver license PERMIT issued by a state or outlying possession of the U.S.
- ID card issued by a federal, state, or local government agency or by a territory of the U.S.
- State ID card (or outlying possession of the U.S.) with a seal or logo from state or state agency
- Commercial driver license, issued by a state or outlying possession of the U.S.
- Department of defense common access card
- Employment authorization document that contains a photograph
- Foreign driver license (Mexico and Canada only)
- Foreign passport
- Military dependent's identification card
- Permanent resident card or alien registration receipt card (form I-551)
- U.S. Coast Guard Merchant Mariner Credential
- U.S. Military identification card
- U.S. passport
- U.S. Tribal card (enhanced only) or U.S. Bureau of Indian Affairs identification card
- U.S. visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the U.S.
- Uniformed Services identification card (form DD-1172-2)

Identification if under 18 and nothing else available:

Persons under the age of 18 who are unable to present an acceptable photograph document listed above shall provide a Social Security card or a birth certificate. The New York Photo ID Waiver for Minors, developed by the New York State Division of Criminal Justice Services, must be completed and signed by a parent or guardian at the time of fingerprinting at the fingerprinting site location.

Do not sign this form in advance.

NOTE: *Staff with fingerprint images on file with OCFS may be eligible for a waiver. Contact the licensor/registrar or director of the program for more information.*

Hard-to-Print Applicants

Please contact the Criminal History Review Unit at 518-473-8595 for instructions.

Instructions for Completing the Statewide Central Register Database Check Form LDSS-3370, DCCS version

ALL information on the **LDSS-3370**, DCCS version must be easily read so that data entry and results are accurate. Each *Statewide Central Register Database Check* form **LDSS-3370**, DCCS version submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

HOW TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Day Care providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of RID number. (Contact your licensing agency/regional office if you have any questions).
- Clearance Category letter code (see the back of form **LDSS-3370**, DCCS version) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: **Must** include street and city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA

ALL HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.

Remember to **write clearly** or **type** all information to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.

- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F/Non-Binary column: check either M (Male) or F (Female) or Non-Binary for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yyyy) for everyone listed on the form.

ADDRESS AREA

The information required varies depending on the category (see the back of the form for categories).

- For Adoption, Foster Care and Family and Group Family Day Care, provide addresses for the applicant and any household member who is 18 years of age or older. **This information must date back to the last 28-years**. Attach supplemental pages if necessary, but **do not use** another **LDSS-3370,** DCCS version form to list this additional information. Be sure to associate address histories with individuals (i.e., indicate which addresses are for which household member).
- For all other categories, only the applicant's address history is required – for the **last 28-years**.
- Complete addresses are required. Include street name, street number, apartment number and city/town/village. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates *(months/years)* of residence. If the applicant has spent time in the military, list base names and locations along with dates *(months/years)*.
- **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on, to the back of the form for the last 28-years. Staple the attached supplemental page to the form if more space is needed, but **do not use** another copy of the **LDSS-3370,** DCCS version for this additional information.

SIGNATURE AREA

- Signatures required depend upon the category (see the back of the form for categories).
- For Adoption, Foster Care and Family and Group Family Day Care, signatures are needed from the applicant and any household member who is 18 years of age or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area. For example: Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked Applicant's Signature; household members over 18 years of age who are not applicants must sign in the boxes at the extreme bottom of the page marked Signature.
- All signatures must be dated (mm/dd/yyyy). The SCR **will not accept** a form with a signature date more than six-months old.

If you have questions regarding completion of this form, **please call the SCR at 518-474-5297.**

SUBMIT YOUR COMPLETED **LDSS-3370,** DCCS VERSION TO THE PERSON REFERENCED IN **OCFS-6000**
BE SURE TO INCLUDE THE REQUIRED FEE - **FEE REQUIRED FOR EACH APPLICANT**

TO ORDER A SUPPLY OF FORM, LDSS-3370, DCCS version**:**

Please access the **OCFS-4627,** *Request for Forms and Publications*, from the Intranet: http://ocfs.state.nyenet/admin/forms/Management_Services/ Internet http://ocfs.ny.gov/main/documents/forms_keyword.asp and mail the completed **OCFS-4627***, Request for Forms and Publications* to: **THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 116 SOUTH BLDG., RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 08/2019) DCCS version FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY (Use alpha codes on reverse):	PHONE NUMBER (Area Code):
				( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS:

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above, are also on the reverse side of this form.

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below.*

(see reverse side for instructions) Attach additional page if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the NYS Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an indicated child abuse or maltreatment report. The utilization of this information in a discriminatory manner is contrary to the Human Rights Law.

APPLICANT/HOUSEHOLD MEMBER AREA **PLEASE TYPE OR PRINT CLEARLY**

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	Sex M/F	DATE OF BIRTH
APPLICANT			☐ M ☐ F	
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
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Please provide your current address and any other addresses at which you have resided for the last 28-years, including street, street number, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 years of age or older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

I affirm that all the information provided on this form is true to the best of my knowledge. I understand that if I knowingly give false statements, such action could be grounds for denial or dismissal from employment or denial or revocation of a license, certificate, permit, registration or approval.

APPLICANT'S SIGNATURE	DATE / /

APPLICANT'S SIGNATURE	DATE / /

EIGHTEEN-YEARS OF AGE OR OLDER:

I understand that as a person 18 years of age or older in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /

SIGNATURE	DATE / /

AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons 18 years of age or older residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY AND GROUP FAMILY DAY CARE also must sign the form.

AGENCY CODE: Record your three-digit agency code. NOTE: Day Care, Family and Group Family Day Care and Camps must provide the agency code of the agency or office which issues your license or certificate. Verify your Alpha or Alpha/Numeric three-digit code with your licensing agency.

DAYCARE PROVIDERS: Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of RID number. (Contact your licensing agency/regional office if you have any questions).

RESOURCE I.D. (RID): Record your RID in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs and local departments of social services, have RIDs as of 9/2001. Verify your RID with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES: Record the appropriate alpha code in the category box.

A– Adult Services/Family Type Home for Adults	**N**- Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*
D- Prospective employee *(Local DSS district - bill against reimbursement)***	**P**- Applying to be a family day care provider. *(fee required - see below)* Provide address history for all household members 18-years old or over.*
E- Current employee	**Q**- Applying to be group family day care provider. *(fee required see below)* Provide address history for all household members 18 years old or over.*
F- Prospective/new employee other than day care employees. (fee required - see below)*	**R**- Applying to be kinship foster parents.
G-This is a provider, employee, volunteer, or household member 18 years of age or older not related to any child in care, at legally-exempt family child care. No checks required when provider is a legally-exempt relative-only family child care provider. (This category is only to be used by Enrollment Agencies)	**S**- Provider of goods/services
	U- Universal Pre-K Teacher *(fee required - see below)**
	W- Applying to be foster parents or family care home providers.
I- This is a provider, employee, or volunteer at a legally-exempt in-home care. No checks required when provider is a legally-exempt relative-only in-home child care provider. (This category is only to be used by Enrollment Agencies)	**X**- Applying to be adoptive parents pursuant to an application pending before the inquiring agency.
J- Age 18 or Older Household Member (with no child care role)	**Y**- Prospective Day Care employee *(fee required - see below)** - Applying to be a Group Family Day Care Assistant. (Fee required - See below)*
L- This is a director, employee, or volunteer at legally exempt group child care. (this category is only to be used by Enrollment Agencies).	**Z**- Prospective volunteer/consultant.
M- Director of a summer camp, overnight camp, day camp or traveling day camp.	

AGENCY LIAISON: Record the name of the person to whom the response should be sent (cannot be the same as applicant or related to the applicant**).**

APPLICANT/HOUSEHOLD MEMBER AREA INSTRUCTIONS: This information is to be provided by the applicant/employee/ provider. (*See front of form).*

APPLICANT(S): -USE FIRST LINE (at least one person must be so designated)

MAIDEN NAME/ALTERNATIVE/AKA: MUST be completed for every applicant. Record **ALL** previous names used. Start with second line. Use as many lines as needed (one last name per line)

OTHER HOUSEHOLD MEMBERS: describe relationship to applicant, e.g., son, daughter, father, mother, friend, etc. on remaining lines (ATTACH ADDITIONAL PAGE IF NECESSARY)

IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

*Social Services Law 424-a requires the collection of a **$25.00 fee** for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to *"New York State Office of Children and Family Services"* in the amount of twenty-five dollars, is to accompany the form. The check must also include the applicant's name and the agency code.
N.B.: a separate check must accompany each form.

**Social Services Law 424-a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, please call the SCR at 518-474-5297.

SUBMIT YOUR COMPLETED FORM, **LDSS-3370,** DCCS VERSION TO THE PERSON REFERENCED IN **OCFS-6000**
BE SURE TO INCLUDE THE REQUIRED FEE – **FEE REQUIRED FOR EACH APPLICANT**

STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: _____

Print clearly, all dates must be consecutive *(month/year)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM

ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: ____________________

Other Household Members are: (please print clearly):

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
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