

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER AND HOUSEHOLD MEMBER REQUIRED FORMS LIST
CHILD DAY CARE PROGRAMS

Staff means all personnel, including directors, caregivers, and non-caregivers, temporary personnel, teachers, aides, para-professionals, cooks, custodians, administrative staff and all other person(s) employed by a child care program.

Volunteer means any unpaid person that is not a caregiver or staff who is present at the day care program for the purpose of assisting with the care of children or the operation of the child care program. A volunteer is not employed by the program and he or she may not be counted in the supervision ratio and may not be left unsupervised with children in care.

The following individual forms listed must be completed as noted in the chart below.

OCFS-6001 STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER INFORMATION – *All Modalities*

OCFS-6002 QUALIFICATIONS – *All Modalities*

OCFS-6003 REFERENCES – *All Modalities*

OCFS-6004 STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT – *All Modalities*

OCFS-6005 CRIMINAL CONVICTION STATEMENT – *All Modalities*

LDSS-3370 STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM AND INSTRUCTIONS FOR COMPLETING THE *-DCCS version*

OCFS-4930 REQUEST FOR NYS FINGERPRINTING SERVICES

*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.

OCFS-6022 STAFF EXCLUSION LIST CHECK

Requirement	G/FDC and SDCC Caregivers	G/FDC Household Member 18 & Older	G/FDC Household Member Under 18 Years Old	G/FDC and SDCC Volunteer	DCC/SACC Staff	DCC/SACC Volunteer
OCFS-6001	X	X	X	X	X	X
OCFS-6002	X				X	X
OCFS-6003	X				X	X
OCFS-6004	X	X	X		X	X
OCFS-6005	X	X		X	X	X
LDSS-3370	X	X		X	X	X
OCFS-4930	X	X		X	X	X
*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.						
OCFS-6022	X	X		X	X	X

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER INFORMATION
CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- Please **PRINT** clearly
- If you are not sure which role to choose, refer to child day care regulations and/or consult with your licensor or registrar.

PROGRAM NAME:	FACILITY ID NUMBER:
PERSONS NAME:	
DATE:	

TYPE OF PROGRAM:	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
ROLE:	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Volunteer <input type="checkbox"/> Employee

IDENTIFYING INFORMATION

- MR. NAME (Last, First, MI):
 MRS.
 MS.

ADDRESS: _____ APT: _____ FLOOR: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ E-MAIL: _____

DATE OF BIRTH (mm/dd/yyyy):
/ /

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
QUALIFICATIONS
CHILD DAY CARE PROGRAMS

PROGRAM NAME:
NAME OF PERSON WITH PENDING ROLE:

FACILITY ID NUMBER:
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 childcare 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	<input type="checkbox"/> Provider <input type="checkbox"/> Assistant <input type="checkbox"/> Substitute	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher <input type="checkbox"/> 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 three people we can contact as references
- 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:	

<u>TYPE OF PROGRAM</u>	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care
ROLE IN PROGRAM	<input type="checkbox"/> Provider <input type="checkbox"/> Assistant <input type="checkbox"/> Substitute	<input type="checkbox"/> Director <input type="checkbox"/> Teacher <input type="checkbox"/> Volunteer

REFERENCE #1

Please check appropriate reference type: Personal Employment

NAME (Last, First, MI):

MR. MRS. MS.

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

Please check appropriate reference type: Personal Employment

NAME (Last, First, MI):

MR. MRS. MS.

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

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 DAY CARE PROGRAMS

INSTRUCTIONS:

- A signature is required on **BOTH sides** of this form. If the only role is a household member, complete front page only.
- Only a health care provider (physician, physician's 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.

Program Name:
Person's Name:

Facility ID Number:
Date of Birth:

<u>TYPE OF PROGRAM:</u>	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
ROLE:	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Volunteer <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Employee

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:			
He/She is currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
He/She has a physical condition that would prevent him/her from providing typical child day care duties as described above.	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> 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 *(continued)*

Program Name:
Person's Name:

Facility ID Number:
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.
- A health care professional (*physician, physician's assistant, nurse practitioner or a registered nurse as part of their 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 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*)
 () -
Phone

Title
 / /
Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- GFDC/FDC programs: return this completed form to your Licensor or Registrar.
- DCC/SACC programs: for Directors-return this completed form to your Licensor or Registrar; for all other staff - return the form to the Director for evaluation.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
CRIMINAL CONVICTION STATEMENT
CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- ALL people with the roles below must complete and sign this Criminal Conviction Statement regardless of conviction status
- This form is in addition to being fingerprinted
- Please **PRINT** clearly

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

<u>TYPE OF PROGRAM</u>	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care	All Programs
<u>ROLE</u>	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC) (over 18)	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Volunteer <input type="checkbox"/> Employee

CONVICTION STATEMENT

Have you previously completed a Conviction Statement?

- NO**, this is the first conviction statement I am signing for child day care.
- YES**, I have signed a previous conviction statement for child day care and...
- All of the following convictions (if any) were previously reported **OR**
- I have added new convictions since the last statement.

CERTIFICATION

In accordance with Section 390-b(1)(b) of the Social Services Law, 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 State or Federal court.**

(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.)

RECORD OF ALL CONVICTIONS

EXAMPLE: Type of Crime	Penal Code Section	Date of Conviction	County or Court of Arraignment
Petit Larceny	155.25	5/1/2013	Albany

Complete the information below and submit with record of conviction or certification of court arraignment. In addition, you may provide written justification on the back of this sheet, explaining why you should be allowed to care for children regardless of any conviction.

<u>Type of Crime</u>	<u>Penal Code Section</u> <i>(if known)</i>	<u>Date of Conviction</u> <i>(mm/dd/yyyy)</i>	<u>County or Court of Arraignment</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 and/or to provide truthful and accurate information concerning the conviction(s) 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): _____

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 CODE:	PHONE NUMBER (Area Code): () -
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:			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	
AGENCY NAME:			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 SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below (see reverse side for instructions) Attach additional page if necessary.	
AGENCY LIAISON:				
STREET ADDRESS				
CITY:	STATE:	ZIP CODE:		

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 N.Y.S. 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**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH		
APPLICANT						
MAIDEN/ALIAS						

Please provide your current address and any other addresses at which you have resided for the last 28 years, including street, city and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO

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
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EIGHTEEN YEARS OLD OR OVER:

I understand that as a person eighteen years of age or over 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
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Instructions for Completing the Statewide Central Register Database Check Form**LDSS-3370**

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check 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.

THE PROPER WAY 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.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) 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, 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 in order 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, indicate NONE on the line below "Maiden/Alias".

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

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant's address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **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 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 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 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/yy). The SCR will not accept a form with a signature date more than 6 months old.

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

**SUBMIT YOUR COMPLETED LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED FEE**

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

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 OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.

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 eighteen years old and over 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 3-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 3 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 Resource ID (RID) number. (Contact your licensing agency/Regional Office if you have any questions).

RESOURCE I.D. (RID)-Record your RESOURCE I.D. (RID) in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs, and Local Departments of Social Services, have RID'S as of 9/01. Verify your RID with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES - Record the appropriate category.

A - Adult Services/Family Type Home for Adults

D - Prospective employee (*Local DSS district - bill against reimbursement*)**

E - Current employee.

F - Prospective/new employee other than day care employees. (fee required - see below)*

J - Over 18 Household member (with no child care role)

M - Director of a summer camp, overnight camp, day camp or traveling day camp.

N - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*

P - Applying to be family day care provider. (*fee required - see below*)*

Q - Applying to be group family day care provider. (*fee required see below*)*

R - Applying to be kinship foster parents.

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.

X - Applying to be adoptive parents pursuant to an application pending before the inquiring agency.

Y - Prospective Day Care employee (*fee required - see below*)*
- Applying to be a Group Family Day Care Assistant. (fee required see below)*

Z - Prospective volunteer/consultant.

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

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 NO OTHER HOUSEHOLD MEMBERS, record NONE on line below MAIDEN/ALIAS.

*Social Service 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 also is to include the applicant's name and the agency code.

N.B.: **a separate check must accompany each form.**

**Social Service 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 LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED FEE**

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

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 OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.

If you have difficulty accessing a form on either site, you can call the automated Forms Request Line at 518-473-0971.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
REQUEST FOR NYS FINGERPRINTING SERVICES
Child Day 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 _____

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 DAY 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 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.

A *New York Photo ID Waiver for Minors* form (OCFS-4931) 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.

Hard to Print Applicants

You may need to be printed in the traditional format of ink-and-rolled prints if you are:

- A) over the age of 18 and have a disabling condition that prevents you from leaving your home; or
- B) if your fingerprints are difficult to print.

The ink and rolled fingerprints should be accompanied by a completed OCFS-4930 *Request for NYS Fingerprinting Services* form and mailed with tracking to the New York State Office of Children and Family Services, Criminal History Review Unit (*at the following address*):

**Capital View Office Park
52 Washington Street
Criminal History Review Unit, Room 209 South
Rensselaer, NY 12144**

* 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.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
WAIVER FOR SUBMISSION OF A DUPLICATE FINGERPRINT CARD

Please Print Clearly or Type Information

1. Last Name	2. First Name	3. M.I.	4. Sex <input type="checkbox"/> Female <input type="checkbox"/> Male	5. Date of Birth Month Day Year
6. Alias or Maiden Name				
7. Street Address			8. Check here if this is a new address <input type="checkbox"/>	
9. City/State Address				10. Zip Code
11. New Facility/Provider ID#	12. New Facility/Provider Name			
13. New Facility/Provider Street Address				
14. New Facility/Provider City/State Address				15. Zip Code

16. Additional Information – Current Role (Check One):

<input type="checkbox"/> D <input type="checkbox"/> T <input type="checkbox"/> J <input type="checkbox"/> TR <input type="checkbox"/> HM <input type="checkbox"/> F <input type="checkbox"/> A
<p>D- Director/Site Operator</p> <p>T- Teacher, Assistant Teacher, Teacher's Aide Assistant in GFDC or FDC</p> <p>J- Janitor/Maintenance Staff</p> <p>TR- Transportation staff, bus drivers, van drivers, transportation aids</p> <p>HM- Household members over the age of 18</p> <p>F- Family or Group family day care provider</p> <p>A- Administrative Staff</p>
<p>17. Have you been previously fingerprinted by the NYS Office of Children and Family Services (OCFS) for day care employment, registration, licensure and/or by a local social services district or a voluntary authorized agency for certification or approval as a foster care/adoption parent or as someone in the household over age 18? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>

18. Please identify previous Facility/Provider/Agency below

Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address
Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address
Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address

I understand that the information I have provided above will be used to complete a criminal history review. To the best of my knowledge, the information I have provided in this document is true and accurate. I also understand that my failure to provide truthful and accurate information in this document may constitute grounds for the denial, suspension, limitation, or revocation of the privileges sought in connection with this application.

19. _____
Signature
Date

PLEASE FORWARD THIS FORM TO YOUR LICENSING OR REGISTRATION REPRESENTATIVE

This form is designed to eliminate the need to submit new fingerprints to the New York State Office of Children and Family Services (NYS OCFS) for the purpose of obtaining a criminal history background check for applicants for day care center/group family day care licenses or employment or volunteers; family day care/school age child care registrations or employment or volunteers. This form is also used for household members over the age of eighteen (18) of applicants who would otherwise be required to submit a fingerprint card.

This form only applies to individuals who have been previously fingerprinted for the purpose described above.

INSTRUCTIONS

PLEASE COMPLETE ALL ITEMS ON FORM

1. Enter applicant's or household member's Last Name
2. Enter applicant's or household member's First Name
3. Enter applicant's or household member's Middle Initial
4. Check "M" for Male **or** "F" for Female
5. Enter applicant's or household member's Date of Birth (mm/dd/yyyy)
6. Alias and/or Maiden Name – Enter any alias or maiden name. Enter any applicable complete name in which the given and /or surname is different than those entered in items 1 thru 3.
7. Enter applicant's or household members a CURRENT Street Address
8. Check here if this is a new address – The address given in items 7 & 9 is different from address when previously fingerprinted
9. Enter applicant's or household member's CURRENT city and state for above address
10. Enter applicant's or member's Zip Code
11. New Facility/Provider ID# - The ID # is the license number of the day care facility or provider
12. New Facility/Provider name - The name of the day care facility or provider for which you are now applying
13. New Facility/Provider street address – The address of the day care facility or provider for which you are now applying
14. New Facility/Provider city/ state address- Enter city and state for above address
15. New Facility/Provider zip code- Enter Zip Code
16. Additional Information – Current Role – Check the box that corresponds with the role for which you are currently applying.
17. Have you previously been fingerprinted for Day Care, Foster Care or Adoption purposes through:
 - The NYS Office of Children and Family Services (OCFS); or
 - By a local social services district or voluntary authorized agency?Check "Yes" ONLY if you have been previously fingerprinted by one or more of these organizations. If you check "No", this form does not apply to you.
18. Previous Facility/Provider/Agency – Enter Facility/Provider/Agency ID# for all locations with which you have previously been affiliated, where you were required to submit a fingerprint card to NYS OCFS in relation to day care, foster care or adoption.
19. This form must be signed and dated by applicant or household member.

This form should only be used if you have already been fingerprinted for child care, foster care, or adoption purposes. This form is meant to be used in lieu of submission of additional fingerprints, and will not be accepted unless fully completed according to the instructions listed above.

UPON COMPLETION: PLEASE FORWARD THIS FORM TO YOUR LICENSING OR REGISTRATION REPRESENTATIVE

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 before an individual has regular and substantial contact with children in child day care programs. This includes providers, staff, and volunteers. It also includes residents 18 years of age and older living in group family day care and family day care homes.

Instructions:

- This form is used to check the Justice Center's Staff Exclusion List (SEL).
- The requirement applies only to those who begin their association with the program after 6/30/13.

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

Type of Program / Position	Where to submit
Family Day Care, Group Family Day Care and Small Day Care Center	The licensor/registrar of the program.
Day Care Center and School Age Child Care Directors	The licensor/registrar of the program.
Day Care Center and School Age Child Care Staff and Volunteers	The director 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 in the space provided below. **PRINT clearly** to avoid delays in processing.

First Name: _____

Last Name: _____

Middle Initial: _____

Social Security Number: _____

Date of Birth *Only if no SSN or Alien Reg. is available:* _____

Alien Registration Number *Only If no SSN is available:* _____

Position applied for: _____