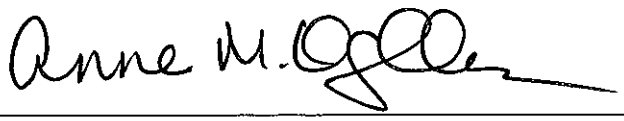
Catholic Charities Disabilities Services
Agency Standard and Procedure

Standard Category	Human Resources
Standard Title	Background Checks for Applicants and Employees
Regulations	Title 14, NYCRR Part 701 Section 16.34 of the Mental Hygiene Law, Section 424-a of the Social Services Law OPWDD: Criminal History Record Checks, Section 633.5 and 633.22), State Central Register Background Checks ADM 98-02
Original Issue Date	May 30, 2009
Latest Revision Date	July 1, 2013
Number of Pages	
Attachments	• Request for Staff Exclusion List Check Form • Applicant Consent Form for Fingerprinting for Justice Center CBC • Request for Criminal History Record Check • Fingerprint Submission Authorization Form • Form OPWDD 152 • LDSS-3370 Statewide Central Register Database Check • USCIS Form I-9 • New Employee Background Clearance Tracking Form
Approved by: **Anne M. Ogden, Executive Director**	

Standard

In order to protect the individuals we serve, Catholic Charities Disabilities Services (CCDS) performs background checks in accordance with State regulations governing programs operated under the auspices of OPWDD, and in accordance with the standards and procedures of Catholic Charities of the Diocese of Albany.

Procedure

The background checks include I9 Verification, E-Verify, NYS DMV Lens license event verification and sanction screening for all employees. In addition, employees who have regular and substantial contact with consumers are subject to a check of

the NYS Staff Exclusion List, criminal background check, employment history records check (MHL 16.34), and State Registry of Child Abuse check.

The Human Resources Department at CCDS processes and maintains background information in accordance with the standards of Catholic Charities of Diocese of Albany, current labor laws and specifically those regulations and laws emanating from the Justice Center, OPWDD and New York State.

The attached New Employee Background Clearance Tracking Form is a flow chart that illustrates the background check process.

New Employee Background Clearance Tracking Form

Employee Name : _____

Position / Department : _____

FINAL CHECKLIST

References completed _____

DMV completed _____

SEL completed _____

MHL 16.34 completed _____

CBC results completed _____

SCR completed _____

Choicepoint completed _____

E-Verify completed _____

Minimum 2 **References** Completed Cleared on _____

→ *Make offer and schedule new hire paperwork*

DMV Abstract Completed Cleared on _____

SEL MUST be cleared before proceeding to next steps

SEL Request

Submitted on _____

Cleared on _____

151/152 (MHL 16.34)

Submitted on _____

Cleared on _____

Applicant may conditionally attend training while awaiting MHL 16.34 results. Applicant may not work in an unsupervised setting until results are received.

CBC / Fingerprints

Submitted on _____

Cleared on _____

CBC MUST be cleared before applicant can attend training

SCR (if applicable)

(certified settings only)

Check requested on _____

Submitted on _____

Cleared on _____

Applicant may conditionally attend training while awaiting SCR results. Applicant may not work in an unsupervised setting until results are received.

Choicepoint

Submitted on _____

Cleared on _____

Choicepoint is a Diocese required check and is the last verification to be performed. Results are usually received same day.

E-Verify

1st-3rd day of employment only

Cleared on _____

E-Verify is done thru the SSA & Dept. of Homeland Security, and can only be performed between the 1st-3rd day of employment.

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464	**Request for Staff Exclusion List Check Form**	

The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow "any person" to have regular and substantial contact with a service recipient. "Any person" can include an employee, administrator, consultant, intern, volunteer, or contractor.

Instructions:

1. The provider's Authorized Person must complete this form and fax it to the Justice Center's Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient.
2. The Justice Center's CBC unit will send the Authorized Person an email indicating the results of the SEL check.
3. If the Applicant is on the SEL, he or she may not be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department.
4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3).
5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted.

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	Alien Reg#:
Applicant address:	Applicant type:	
Facility/Provider Name: Catholic Charities Disabilities Services Address: 1 Park Place, Suite 200 Albany NY 12205		
State Oversight Agency: OMH (OPWDD) OCFS DOH SED OASAS		Please circle appropriate agency(ies)

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)	Holly Durivage	Email:	Hollyd@ccdservices.org
Signature:	Holly Durivage	Phone:	518-783-1111
Facility/Provider name:	Catholic Charities Disabilities Services	Address:	1 Park Place, Suite 200 Albany, NY 12205

NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464 Email: cbc@JusticeCenter.ny.gov	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	

Part 1. Applicant Information (Please print clearly)

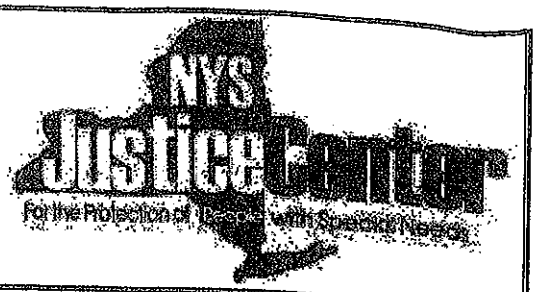
Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	
Applicant address:	Applicant type:	
Facility/Provider: Catholic Charities Disabilities Services		
State Oversight Agency: OMH OPWDD OCFS		Circle all that apply

Part 2. Attestation

1. I have been advised that as part of the application process, the law requires the facility or provider agency listed above to request a criminal history information check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and authorizes the Justice Center to review and evaluate the results of the criminal history information check received by DCJS and FBI. The Justice Center will provide a summary of NYS criminal history, if any, to the facility or provider agency. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted for the purpose of a criminal history information check to DCJS and the FBI and consent to the Justice Center sharing with the facility for provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal history information check forwarded to the Justice Center by DCJS and the FBI shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   ____ have been convicted of a crime in New York State or any other jurisdiction.
   ____ have pending arrest charges.
   If checked, provide details:_____
   _____
8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List which is maintained as part of the Vulnerable Persons' Central Register and that such check is required by Social Services Law §495 and will be performed prior to the criminal history information check. 14 NYCRR Part 702 provides for the collection of social security numbers for this purpose and the failure to provide my social security number may preclude me from being considered for the position applied for.

Applicant Signature		Date:
Signature Parent/ Guardian if Applicant under 18 years		Date:
Part 3	**Facility of Provider Agency Authorized Person Information**	
Name:	Holly Durivage	Title: Human Resources Mgr
Signature:	Holly Durivage	Email: Hollyd@ccdservices.org

JC CBC 6/7/13

Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464 Email: cbc@JusticeCenter.ny.gov	**Request for Criminal History Record Check**	

The purpose of this form is to formally request a criminal history record check. For state employees, DDSO should use Form OPWDD 106S.

Instructions:

1. Complete **all** fields on the form. Please print legibly.
2. Authorized person must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Form JC CBC Unit at PO Box 3003, Schenectady, NY 12303-0005.

Agency/DDSO /Registered Provider Name	Five Digit ID Number	Check Type
Catholic Charities Disabilities Services	10240	☐ DDSO ☒ Voluntary Provider ☐ Registered Provider

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

Status (check one)

- ☒ E – Employee (non state)
- ☐ V – Volunteer
- ☐ F – Family Care Provider
- ☐ N – Employees of vendors and contractors

Program Type

For Voluntary Agencies enter four digit code from page 2

____ ____ ____ ____

For Registered Providers select either:

- ☐ Transportation 0670
- ☐ Subcontract Service 0880

The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Please check if applicable:

☐ The subject party is a subject party for a position which requires simultaneous criminal history record checks by both Justice Center and OASAS.

Name of Authorized Person Holly Durivage E-mail Hollyd@ccdservices.org

Signature of Authorized Person Holly Durivage Date 1/13

NYS Justice Center for the Protection of People with Special Needs (Justice Center)
Criminal Background Check Unit
161 Delaware Avenue
Delmar, NY 12054
Email:
cbc@JusticeCenter.ny.gov

Fingerprint Submission Authorization Form

This form provides NYS Division of Criminal Justices Services (DCJS) the information necessary to process the fingerprints that are submitted. The information is required when using LIVESCAN or when scanning prints from fingerprint cards. The form must be completed prior to presentation to the LIVESCAN operator, however, the operator will confirm that information on the form matches the physical attributes of the applicant and may change the information to reflect actual physical attributes. The LIVESCAN operator MUST confirm the identification of the applicant by means of one of the following documents which includes a photograph: valid driver's license, valid school identification document, valid passport, or valid military identification. If one of these is not available, documents that can confirm identity for employment purposes can be utilized. If "ink and roll" is being used the individual taking the prints must confirm the identification of the applicant.

Instructions:

1. Complete ***all*** fields on the form. Please print legibly.
2. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
3. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Fingerprint Submission Form to the JC CBC Unit at PO Box 3005 Schenectady, NY 12303-0005.

Applicant

Last Name	First Name	Middle Name	Suffix

Social Security Number	Date of Birth	Birth State	Birth Country

Citizenship	Alien Registration # if applicable

Gender:

☐ Male ☐ Female

Race: Check the code which best describes the person.

☐ W (white) ☐ B (black)
☐ I (American Indian or Alaskan Native) ☐ A (Asian or Pacific Islander)
☐ U (Unknown) ☐ O (Other)

Eye Color: Check the eye color code which best describes the person's eye color.

☐ BLK – Black ☐ GRY – Gray ☐ MAR – Maroon ☐ XXX – Unknown
☐ BLU – Blue ☐ GRN – Green ☐ PNK – Pink ☐ MUL – Multi-color
☐ BRN – Brown ☐ HAZ – Hazel

Hair Color: Check the hair color code which best describes the person's hair color.

☐ BAL – Bald ☐ BRO – Brown ☐ SDY – Sandy ☐ BLU – Blue
☐ BLK – Black ☐ GRY – Gray ☐ WHI – White ☐ GRN – Green
☐ BLN – Blonde ☐ RED – Red ☐ XXX – Unknown ☐ ONG – Orange
☐ PNK – Pink ☐ PLE – Purple

Skin Tone			Ethnic Origin (Enter either Hispanic or Non-Hispanic)
☐ Albino	☐Light	☐Ruddy	
☐Black	☐Light Brown	☐Sallow	
☐Dark	☐Medium	☐Yellow	
☐Dark Brown	☐Med Brown	☐Other	
☐Fair	☐Olive	☐Unknown	

Weight (enter whole numbers only)	Height (enter feet and inches)

Driver's License State	Driver's License Number

Street Address	

City	State	Zip

County	Country

Applicant Type: Check appropriate response (check only one)

☒ Direct Service Provider ☐ Operator
☐ Family Care ☐ Volunteer

Aliases (this includes maiden name)

Last Name	First Name	Middle Name	Suffix

Position: Choose the appropriate type (check only one)

☐Administration	☐Food Service	☐Other Support	☐Rehabilitation
☐Other Support	☐Housekeeping	☐Physician-non-Psychiatric	☐Research
☒Direct Care	☐ Intensive Case Mgmt	☐Psychiatry	☐Residential Care
☐Clinical Ancillary Services	☐ Maintenance & Engineering	☐Psychology	☐Safety
☐Clinical Mgmt	☐ Nursing	☐Quality Assurance	☐Social Work

Justice Center/OASAS Waiver
☐ Yes ☒ No

☒ New Hire
OR
☐ Transfer from other Provider/Program/Agency

Program Code (enter four digit code from Page 3)

Job Duties: Please enter detailed information about the job duties that indicate **how** the applicant will have direct and substantial unsupervised contact with persons receiving services/care and to what degree. (150 Character limit) Direct Care

User Department Division – Please enter the name of the DDSO, agency or registered provider with which the applicant will be associated.

DDSO/Agency/Registered Provider Name Catholic Charities Disabilities Services

FORM OPWDD 151 (8/2013)

1. DATE OF SUBMISSION	**State of New York** **OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES** **Request for MHL §16.34** **ABUSE/NEGLECT HISTORY CHECK**
2. APPLICANT NAME	
3. APPLICANT SSN	
4. APPLICANT DOB	
5. AUTHORIZED PERSON NAME Holly Durivage	
6. AUTHORIZED PERSON EMAIL ADDRESS Hollyd@ccdservices.org	
7. PROVIDER OF SERVICES NAME Catholic Charities Disabilities Services	
8. IS THE PROVIDER A REGISTERED PROVIDER? 1 ■ YES 2 ☐ NO *(note that Registered Providers are required to submit requests for MHL 16.34 checks)*	
9. PROGRAM TYPE (select four digit code from page 2) ____ ____ ____ ____ *(same as listed on CBC request)*	
10. APPLICANT IS: 1 ■ Prospective Employee 2 ☐ Prospective Volunteer	
11. WAS AN **SEL** REQUEST SUBMITTED? 1 ■ YES 2 ☐ NO	
12. WAS A **CBC** REQUEST SUBMITTED, OR WILL ONE BE SUBMITTED? 1 ■ YES 2 ☐ NO	

INSTRUCTIONS:

This form must be submitted to OPWDD for all prospective employees and volunteers in the OPWDD system. The form must be submitted by all certified and non-certified programs and registered providers.

The purpose of this form is to request that OPWDD conduct a check of records of substantiated allegations of abuse and neglect that occurred or were discovered prior to June 30, 2013 and that involved the applicant. This supplements the check of the "Staff Exclusion List" (SEL) requested from the Justice Center which concerns substantiated abuse and neglect that occurred on or after June 30, 2013.

FORM OPWDD 152 (8/2013)

INSTRUCTIONS:

This form is to be completed by a prospective employee or volunteer. Complete all fields. If exact dates are not known, give approximate dates. Submit the completed form to your potential employer or organization with which you are applying to volunteer.

State of New York
OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

APPLICANT INFORMATION

1. NAME

2. SOCIAL SECURITY NUMBER

3. DATE OF BIRTH

4. MAILING ADDRESS (include Street Address, Apt. #, City, State, Zip and County

5. PROVIDER OF SERVICES NAME

Catholic Charities Disabilities Services

6. List complete employment history for the past 7 years, including the start and end date. Begin with the most recent employment and list employers in chronological order. Use an additional sheet if needed.

Full Name of Employer	Location (e.g., city, state)	Start Date	End Date

7. List all employment history serving people with developmental disabilities that occurred beyond 7 years. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Employer	Location (e.g., city, state)	Start Date	End Date

8. List all volunteer work for the past 7 years and volunteer work serving people with developmental disabilities at any time. Write "none" if there is no history. Use an additional sheet if needed.

Full Name of Agency/Organization	Location (e.g., city, state)	Start Date	End Date

I CERTIFY that the information provided in this form is true and correct to the best of my knowledge and belief, and authorize investigation of all information given.

The provision of false information is grounds for dismissal.

SIGNATURE: _____ DATE: _____

AGENCY CERTIFICATION: I certify that I have reviewed the employment/volunteer history provided by this applicant and that, to the best of my knowledge, the applicant has no employment/volunteer history in the OPWDD system. I also certify that I am an individual designated as an "authorized person" who is authorized to request and receive criminal history information pursuant to exec. L. 845-b.

SIGNATURE: _____ DATE: _____

If the Provider of Services agency has certified the applicant has no employment/volunteer history with OPWDD, the agency may hire the applicant and must retain this form as documentation.

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.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

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/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ 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.**

LDSS-3370 (Rev. 04/2011) 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 CODE:	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 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 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

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

LDSS-3370 (Rev. 04/2011)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

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.state.ny.us

CLEARANCE CATEGORIES
Record the appropriate category.

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

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

Y - Prospective Day Care employee (fee required - see below)*

S - Provider of goods/services

Y - Applying to be a group family day care assistant. (fee required - see below)*

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

Z - Prospective volunteer/consultant.

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

W - Applying to be foster parents or family care home providers.

R - Applying to be kinship foster parents.

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

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

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

E - Current employee.

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 regarding proper completion of this form, please call the SCR at 518-474-5297.

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480, Attention: Service Center Unit
ALBANY, N.Y. 12204-0480

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/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ 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 hotline at 518-473-0971.

LDSS-3370 (Rev. 04/2011)

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ______________________________

Other Household Members are (please print clearly):

SCR Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y

Employment Eligibility Verification

Department of Homeland Security
U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 03/31/2016

▶START HERE. Read instructions carefully before completing this form. The instructions must be available during completion of this form.
ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) they will accept from an employee. The refusal to hire an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	Zip Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	E-mail Address	Telephone Number
	☐☐☐-☐☐-☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following):

☐ A citizen of the United States

☐ A noncitizen national of the United States *(See instructions)*

☐ A lawful permanent resident (Alien Registration Number/USCIS Number): _____

☐ An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy) _____. Some aliens may write "N/A" in this field. *(See instructions)*

*For aliens authorized to work, provide your Alien Registration Number/USCIS Number **OR** Form I-94 Admission Number:*

1. Alien Registration Number/USCIS Number: _____

OR

2. Form I-94 Admission Number: _____

If you obtained your admission number from CBP in connection with your arrival in the United States, include the following:

Foreign Passport Number: _____

Country of Issuance: _____

Some aliens may write "N/A" on the Foreign Passport Number and Country of Issuance fields. (*See instructions*)

3-D Barcode
Do Not Write in This Space

Signature of Employee:	Date *(mm/dd/yyyy)*:

Preparer and/or Translator Certification *(To be completed and signed if Section 1 is prepared by a person other than the employee.)*

I attest, under penalty of perjury, that I have assisted in the completion of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator:			Date *(mm/dd/yyyy)*:
Last Name *(Family Name)*	First Name *(Given Name)*		
Address *(Street Number and Name)*	City or Town	State	Zip Code

STOP ***Employer Completes Next Page*** STOP

Section 2. Employer or Authorized Representative Review and Verification

(Employers or their authorized representative must complete and sign Section 2 within 3 business days of the employee's first day of employment. You must physically examine one document from List A OR examine a combination of one document from List B and one document from List C as listed on the "Lists of Acceptable Documents" on the next page of this form. For each document you review, record the following information: document title, issuing authority, document number, and expiration date, if any.)

Employee Last Name, First Name and Middle Initial from Section 1:

List A Identity and Employment Authorization	OR	List B Identity	AND	List C Employment Authorization
Document Title:		Document Title:		Document Title:
Issuing Authority:		Issuing Authority:		Issuing Authority:
Document Number:		Document Number:		Document Number:
Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:		Expiration Date *(if any)(mm/dd/yyyy)*:
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				
Document Title:				
Issuing Authority:				
Document Number:				
Expiration Date *(if any)(mm/dd/yyyy)*:				

3-D Barcode
Do Not Write in This Space

Certification

I attest, under penalty of perjury, that (1) I have examined the document(s) presented by the above-named employee, (2) the above-listed document(s) appear to be genuine and to relate to the employee named, and (3) to the best of my knowledge the employee is authorized to work in the United States.

The employee's first day of employment *(mm/dd/yyyy)*: _____ ***(See instructions for exemptions.)***

Signature of Employer or Authorized Representative	Date *(mm/dd/yyyy)*	Title of Employer or Authorized Representative
Last Name *(Family Name)* First Name *(Given Name)*		Employer's Business or Organization Name
Employer's Business or Organization Address *(Street Number and Name)*	City or Town	State / Zip Code

Section 3. Reverification and Rehires *(To be completed and signed by employer or authorized representative.)*

A. New Name *(if applicable)* Last Name *(Family Name)* First Name *(Given Name)* Middle Initial	B. Date of Rehire *(if applicable) (mm/dd/yyyy)*:

C. If employee's previous grant of employment authorization has expired, provide the information for the document from List A or List C the employee presented that establishes current employment authorization in the space provided below.

Document Title:	Document Number:	Expiration Date *(if any)(mm/dd/yyyy)*:

I attest, under penalty of perjury, that to the best of my knowledge, this employee is authorized to work in the United States, and if the employee presented document(s), the document(s) I have examined appear to be genuine and to relate to the individual.

Signature of Employer or Authorized Representative:	Date *(mm/dd/yyyy)*:	Print Name of Employer or Authorized Representative:

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A Documents that Establish Both Identity and Employment Authorization	OR	LIST B Documents that Establish Identity	AND	LIST C Documents that Establish Employment Authorization
1. U.S. Passport or U.S. Passport Card		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
2. Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**3.** School ID card with a photograph		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
4. Employment Authorization Document that contains a photograph (Form I-766)		**4.** Voter's registration card		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record		**5.** Native American tribal document
		6. Military dependent's ID card		**6.** U.S. Citizen ID Card (Form I-197)
		7. U.S. Coast Guard Merchant Mariner Card		**7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
		8. Native American tribal document		**8.** Employment authorization document issued by the Department of Homeland Security
		9. Driver's license issued by a Canadian government authority		
		For persons under age 18 who are unable to present a document listed above:		
		10. School record or report card		
		11. Clinic, doctor, or hospital record		
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**12.** Day-care or nursery school record		

Illustrations of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to Section 2 of the instructions, titled "Employer or Authorized Representative Review and Verification," for more information about acceptable receipts.