OASAS Improving Lives.
NEW YORK STATE
OFFICE OF ALCOHOLISM & SUBSTANCE ABUSE SERVICES
Addiction Services for Prevention, Treatment, Recovery

Governor
Andrew M. Cuomo

Commissioner
Arlene González-Sánchez, M.S., L.M.S.W.

IMPORTANT: PLEASE READ CAREFULLY!!

May 14, 2013

Dear Colleague:

You recently received a letter from me requesting that you submit the attached attestation form by May 8, 2013 so that your program would be allowed to receive criminal background and other information regarding the hiring of new employees after June 30, 2013.

For those of you who have not returned the form, you must do so **IMMEDIATELY** or your program will not be able to hire new employees after June 30, 2013 and you will not be in compliance with the new Justice Center law. http://www.governor.ny.gov/Justice4SpecialNeeds/home

Sincerely,

Robert A. Kent
General Counsel

PLEASE RETURN COMPLETED FORM TO:		
OASAS Criminal Background Check Unit, Counsel's Office **1450 Western Avenue** **Albany NY 12203** **Fax: 518-485-2335** **Email: legal@oasas.ny.gov** **NYS Justice Center for the Protection of People with Special Needs** **Criminal Background Check Unit** **161 Delaware Avenue** **Delmar, NY 12054** **Email: cbc@JusticeCenter.ny.gov**	**Authorized Person Designation/Notarized Sworn Statement Form** **Office of Alcoholism and Substance Abuse Services (OASAS) Criminal Background Check (CBC)** **& Staff Exclusion List (SEL) Check**	**Provider Name:** Provider Number: Address: City: Zip: Telephone Number: Fax: **State Oversight Agency: OMH, OPWDD, OASAS, OCFS (circle all that apply)**

The purpose of this form is to designate the Authorized Person for your agency who will be permitted to request, on behalf of the Provider Agency, a check of the Staff Exclusion List (SEL) and a criminal background check (CBC) pursuant to relevant statutory authority and to request permission for this Authorized Person to access the Justice Center/OASAS CBC system. By signing this form, each signatory attests that all requests made by the Authorized Person for a check of the SEL by the Justice Center or OASAS and a CBC on each prospective employee, volunteer, consultant or natural person operator ("subject individual") will be made in conformance with the law.

INSTRUCTIONS:

1. Please complete all Parts of this form (one form for each Authorized Person).
2. The Authorized Person and the Director of the Provider Agency must sign and date this form where indicated.
3. The Authorized Person must sign Part 3 in the presence of a Notary Public.
4. Please return the completed form to the Justice Center and OASAS. The form may be mailed, scanned and emailed, or faxed to the OASAS CBC Unit at the contact information above.

Part 1. Authorized Person (Please Print)

Last Name:	First Name:	M. I.:
Business Email Address:	Business Phone #	
CASAC or License Num:	Title:	
Business Address (Street):		
City:	State:	Zip:

I understand that my access to the OASAS/Justice Center CBC system is granted for the sole purpose of performing responsibilities related to a request for a check of the SEL and the request, receipt and review of criminal history summaries pursuant to relevant statutory authority. I agree that such requests will be made solely to carry out those specific responsibilities. I further understand that the results of a SEL check and criminal history summaries will only be used and disseminated for purposes authorized by law, and I agree to abide by the confidentiality requirements set forth in Social Services Law §496, Executive Law §845-b, Labor Law §203-d and Article 6-A of the Public Officers Law MHL 19.20(b)(3) and 19.20A.

Signature of Authorized Person:	Date:

Part 2. Provider Approval (DIRECTOR OF THE PROVIDER AGENCY MUST APPROVE DESIGNATION OF AUTHORIZED PERSON BY SIGNING BELOW)

I hereby designate the person identified in Part 1 of this form to serve as the Authorized Person for the Provider Agency noted on this form. I also request access and appropriate permission for this person to use the Justice Center CBC system in support of this responsibility.

Name (Please Print):	Title:
Signature:	Date:

Part 3. Authorized Person Signature and Notary Acknowledgement

By submitting a request for a SEL check and a CBC through the Justice Center/or OASAS CBC system on behalf of the above-named Provider Agency, I hereby attest to the following:

1. I am a duly Authorized Person for the Provider Agency. As such, I am authorized to request a check of the SEL pursuant to Social Services Law §495(2) and to request, receive, and review criminal history information for this Provider Agency in accordance with the relevant statutory provisions.
2. Each request for a check of the SEL and a CBC will be made by a person authorized to make such a request and each request entry will identify the subject individual by his or her name, and will identify the subject individual as either a prospective operator, employee, volunteer or consultant of the Provider Agency who will have regular and substantial unsupervised or unrestricted physical contact with the Provider Agency's clients. For each request entry, the specific duties of the subject individual which permit the Provider Agency to request a CBC will be identified.
3. Each subject individual will be informed that the Provider Agency is authorized to request a check of the SEL and a CBC and that if the SEL check results in a determination that the subject individual should not be hired or retained, a CBC will NOT be performed.
4. Each subject individual will be informed: 1) that he or she may, pursuant to Social Services Law §494, challenge the determination that resulted in placement on the SEL; and 2) of the right to obtain, review and, if necessary, seek correction of his/her criminal history information under regulations established by the NYS Division of Criminal Justice Services. The signed, informed consent of each subject individual will be obtained prior to requesting a check of the SEL or CBC and maintained by the Provider Agency.
5. The results of each check of the SEL and CBC will be used by the Provider Agency solely for the purposes authorized by law.
6. Upon information and belief, the Provider Agency, its agents, and employees are aware of and will abide by the confidentiality requirements of Social Services Law §496, Executive Law §845-b, Labor Law §203-d and Article 6-A of the Public Officers Law.

Authorized Person Signature:		Date :

Acknowledgment to be completed by a Notary Public

State of _____

County of _____

On this _____ day of _____, 20____, before me personally appeared _____

To me known and known to me to be the same person described in and who executed the foregoing instrument, and __he duly acknowledged to me that __he executed same.

_____

Notary Public
(Please sign, affix stamp and include expiration date.)