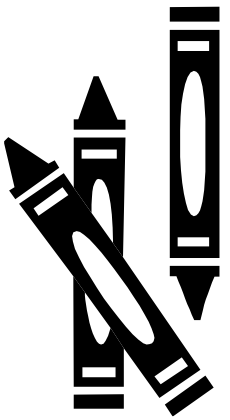
New York State
Office of Children and Family Services

Division of
Child Care Services

New York State Group Family Day Care



Pursuant to the Americans with Disabilities Act, the State Office of Children and Family Services will make this material available in large print or on audiotape upon request.

Printed on Recycled Paper

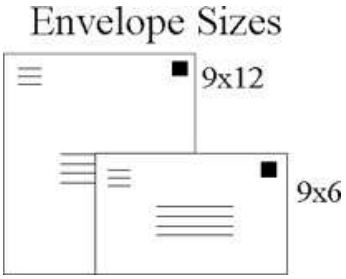
Thank you for inquiring about starting a Group Family Day Care program. We are pleased to send you an application package. Please note that once you submit any part of the application, you must submit all remaining documentation within 90 days. After that, the application will be considered withdrawn.

Becoming a Provider

Operating a group family day care program can be a rewarding professional decision. It is also a business decision that requires that you understand your responsibilities and obligations. While much of the information you will need to make that decision is contained in this application package, there are other sources of information as well. The NYS Office of Children and Family Services encourages you to contact the licensor listed below and your local child care resource and referral (CCRR) agency for additional technical assistance.

Filling out the Application

This package contains the information you will need to begin the application process. The checklist, "Group Family Day Care Required Documents", specifies each item which needs to be completed and submitted to begin your application with us. You can use this checklist to make sure you've completed the application.



Mailing in the Application

ALL pages marked "Submit" should be mailed at the same time if possible. Those pages are perforated for easy removal. It is *required* that you retain documents marked "Maintain on Site". It is *recommended* that you keep copies of everything you submit.

You will need to obtain a large envelope to mail your application to us - a regular business envelope will not be big enough. The illustration to the left shows two envelope sizes that will hold all of your application pages.

Important Information Regarding Union Membership

Family-based child care providers are supported and represented by two unions in New York State: CSEA VOICE (Voice of Organized Independent Child Care Educators) and UFT (UFT Home Child Care Providers). Under the umbrella of CSEA, VOICE represents registered family and licensed group family providers in 57 counties across New York (outside of NYC), and the UFT represents providers in the five boroughs of New York City. Please use the contact information below if you would like to learn how these organizations can support the valuable work you do nurturing and teaching young children and their families.

UFT (programs in NYC)
Phone: 212-598-9288
www.uftproviders.org
e-mail: uftproviders@uft.org

VOICE (all others)
Toll Free: 800-342-4146 ext. 1401
www.voicecsea.org
e-mail: voice@cseainc.org

Helpful Resources & Information

Below are some additional sources of information that you can and should use as you complete the application to provide child care in your home. If you do not have internet access either at home or at your local public library, this information can also be obtained by contacting

Child Care Regulations and Policies

Child Care Regulations:	www.ocfs.state.ny.us/main/childcare/regs/413Definitions.asp
	www.ocfs.state.ny.us/main/childcare/regs/416_GFDC_regs.asp
Division of Child Care Services Policies:	www.ocfs.ny.gov/main/childcare/policies/default.asp
Social Service Law 390:	www.ocfs.state.ny.us/main/childcare/390%20Social%20Services%20Law.doc

Various Household Hazards

Lead information:	www.health.ny.gov/environmental/lead/
Pesticide information:	www.ocfs.state.ny.us/main/childcare/pest/
Radon Information:	www.ocfs.state.ny.us/main/childcare/radon/

Education and Training

Provider Training:	www.ocfs.state.ny.us/main/childcare/training.asp www.ecetp.pdp.albany.edu
Educational Incentive Program:	ecetp.pdp.albany.edu/eip.shtm
Medication Administration Training:	www.ecetp.pdp.albany.edu/mat.shtm
Health and Safety Training:	ecetp.pdp.albany.edu/about_health_safety.shtm
Aspire (training resources):	www.nyworksforchildren.org/Aspire/TeachersandProviders.aspx

General Information

OCFS Website (home page):	www.ocfs.state.ny.us/main
Child Care Resource and Referral Agencies:	www.ocfs.state.ny.us/main/childcare/referralagencys.asp
Local Departments of Social Services:	www.ocfs.state.ny.us/main/localdss.asp
Downloadable Child Care Forms:	www.ocfs.state.ny.us/main/documents/docsChildCare.asp
Quality Stars New York:	qualitystarsny.org/
Listing of County Health Departments:	www.health.state.ny.us/nysdoh/lhu/map.htm
National Association for the Education of Young Children:	www.naeyc.org
American Association of Pediatrics:	www.aap.org

Your Group Family Day Care Application Package

Prepared For:

Your Package Includes:

Group Family Day Care Required Documents

INSTRUCTIONS

Maintain On-Site

- *This listing specifies those documents that you are required by regulation to submit and/or maintain on-site*
- *Use this form to keep track of the required documents and when they are submitted*

Document Listing

✓ Regulation requirements
It is recommended that you maintain a copy of everything you submit

All forms are subject to approval. Care may not be provided until a license has been issued.

Document Name	Page	Maintain On-Site	Submit	Date Submitted
Identifying Information	A-1			
General Information	A-3 and A-4		✓	/ /
Business Information	A-5 thru A-8		✓	/ /
Requirements	B-1			
First Aid & CPR Requirement	B-3	✓	✓	/ /
Fingerprint Request Form	B-7			/ /
Applicant				
Qualifications	B-9		✓	/ /
References	B-11		✓	/ /
SCR Form	B-13 thru B-19		✓	/ /
Staff Exclusion List (SEL)	B-22 and B-23		✓	/ /
Medical Statement	B-25 and B-26	✓	✓	/ /
Criminal Conviction Statement	B-27 and B-28		✓	/ /
Required Assistant				
Information	B-29		✓	/ /
Qualifications	B-31		✓	/ /
References	B-33		✓	/ /
SCR Form	B-35 thru B-41		✓	/ /
Staff Exclusion List (SEL)	B-44 and B-45		✓	/ /
Medical Statement	B-47 and B-48	✓	✓	/ /
Criminal Conviction Statement	B-49 and B-50		✓	/ /

Group Family Day Care Required Documents (continued)

INSTRUCTIONS

Maintain On-Site

- *This listing specifies those documents that you are required by regulation to submit and/or maintain on-site*
- *Use this form to keep track of the required documents and when they are submitted*

Document Listing

✓ Regulation requirements
It is recommended that you maintain a copy of everything you submit

All forms are subject to approval. Care may not be provided until a license has been issued.

Document Name	Page	Maintain On-Site	Submit	Date Submitted
***Requirements** (continued)*				
Other Caregivers				
Information	B-51		✓	/ /
Qualifications	B-53		✓	/ /
References	B-55		✓	/ /
SCR Form	B-57 thru B-63		✓	/ /
Staff Exclusion List (SEL)	B-66 and B-67		✓	/ /
Medical Statement	B-69 and B-70	✓	✓	/ /
Criminal Conviction Statement	B-71 and B-72		✓	/ /
Household Member(s)				
Medical Statement	B-73	✓	✓	/ /
Criminal Conviction Statement	B-75 and B-76		✓	/ /
Site Information	C-1			
Safety Considerations	C-3		✓	/ /
Report of Water Supply Testing	C-5	✓	✓	/ /
Fuel Burning System Inspection	C-7 and C-8	✓	✓	/ /
Environmental Hazard Inspection	C-11 and C-12	✓	✓	/ /
Inside Floor Plan	C-15		✓	/ /
Outside Play Area	C-16		✓	/ /
Emergency Plan	C-19 and C-20	✓	✓	/ /
Emergency Evacuation Diagram	C-23	✓	✓	/ /
Emergency Plan: Shelter in Place	C-27 and C-28	✓	✓	/ /

(Continued on Reverse Side)

Group Family Day Care Required Documents (continued)

INSTRUCTIONS

Maintain On-Site

- *This listing specifies those documents that you are required by regulation to submit and/or maintain on-site*
- *Use this form to keep track of the required documents and when they are submitted*

Document Listing

✓ Regulation requirements
It is recommended that you maintain a copy of everything you submit

All forms are subject to approval. Care may not be provided until a license has been issued.

Document Name	Page	Maintain On-Site	Submit	Date Submitted
Program Information	D-1			
Behavior Management	D-3	✓	✓	/ /
Developing Your Program	D-5 thru D-6	✓	✓	/ /
Program Hours of Operation	D-7	✓	✓	
Program Daily Schedule	D-9	✓	✓	
Health Care Plan	D-11 and D-12	✓	✓	/ /
Agreements	E-1			
Child Support Obligation Statement	E-3		✓	/ /
Applicant Compliance Agreement	E-5		✓	/ /
Business Documents				
DBA (Doing Business As)	Town Clerk	✓ as needed	✓ as needed	
Incorporation Papers	Your Attorney	✓ as needed	✓ as needed	/ /
Pre-service Health and Safety Training Certificate			✓	/ /

Identifying Information

This page left blank intentionally.

General Information

INSTRUCTIONS

Submit

- *All applicants must be 18 years of age or older and must complete this page*
- *Please complete BOTH sides of this form*
- *Please PRINT clearly*

You May Not Need to Complete this Entire Application Booklet!
If changing sites, expanding your program or changing the type of care, contact your licensor.

Applicant

Complete/verify the following information about yourself.

☐ Mr. ☐ Mrs. ☐ Ms. Name: _____ Date of Birth: / / (mm/dd/yyyy)

Last First MI

Mailing Address: _____ Apt. _____ Floor _____ Phone: ( ) Ext.

Unlisted: ☐ **Yes** ☐ **No**

City: _____ State Zip Fax: ( )

County/Borough: _____ E-Mail: _____

Do you speak English? ☐ **Yes** ☐ **No** If no, please specify language(s) spoken: _____

Have you ever provided Legally Exempt child care? ☐ **Yes** ☐ **No**

Do you provide care for adults? ☐ **Yes** ☐ **No** Do you provide foster care? ☐ **Yes** ☐ **No**

Are you approved or licensed to provide in-home care for adults or children? ☐ **Yes** ☐ **No**

Have you ever operated or been employed in licensed or registered day care in New York State? ☐ **Yes** ☐ **No**

If yes, provide prior facility information: Facility Name: _____ Dates: ___/___ - ___/___

Facility Address: _____

Household Members

Please identify everyone (excluding yourself) who is living at the site where care will be provided.
Attach additional sheets if necessary.

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

Name: _____ Date of Birth: / / (mm / dd / yyyy)
Last First MI

(Continued on reverse side)

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General Information (continued)

INSTRUCTIONS

- *In addition to this form you will need to include proof that site is being used as a residence*
- *Please PRINT clearly*

Applicant Name:

Site

Print the following information about your program.

Provider: _____ (Last / First / MI)

Site Address: _____

_____ (Apt. / Floor)

City: _____

_____ (State / Zip)

County/Borough: _____

The Office lists names and addresses of child care providers on its website to enable parents to search for providers. Check below if you do NOT want your address to be listed:

☐ Do NOT list my street address

Phone: ( ) Ext.

Unlisted: ☐ **Yes** ☐ **No**

Fax: ( )

E-Mail[1]:

Mailing Address (if different from site address):

Proof of Residence

Documentation must be submitted to verify that the site is being used as a personal residence. Examples of acceptable documentation include copies of: driver's license, NYS Non-Driver ID, or lease or rental agreement.

Directions to Site

Give detailed directions to your program from the nearest highway, major intersection, bus stop or subway entrance. List all major landmarks. Be specific concerning exit numbers and road names.
Feel free to supplement these instructions with a drawing or map.

[1] OCFS may share your site's email address with state, local or federal agencies responsible for aspects of public health and safety that might impact the children in your care.

Business Information

INSTRUCTIONS

Submit

- *If you have a DBA (Doing Business As), submit your DBA certificate with the application*
- *Complete Legal information section (Check ONE box only). Be advised that once licensed, any change to this information may require a new application*
- *Please PRINT clearly*

Applicant Name:

Legal Entity Selection (Select ONLY ONE checkbox)

►Child day care is a business. It is important for you to select a business type that best meets your needs. Information on legal entity types is available from the New York State Department of State on their website at http://www.dos.ny.gov/ and the New York State Empire State Development Corporation on their website at http://esd.ny.gov/. You may also want to consult with an accountant and/or an attorney prior to making your selection.

☐ **Sole Proprietor**

☐ DBA form attached

Program Name: _____

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

☐ **Corporation**

Corporate Name: _____ DBA: _____

☐ DBA form attached

Federal ID: ☐☐-☐☐☐☐☐☐☐

Mailing Address: _____ Fax: ( )

Apt. _____

E-Mail: _____

Floor _____

City: _____ Contact Name: _____

State Zip

County/Borough: _____ Contact Phone: ( )

Board Member

List the name, title, home address and phone number of a Board Member of the corporation

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

(Continued on reverse side)

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Business Information (continued)

Legal Information (continued)

☐ Legal Partnership

Legal Name: _____ DBA: _____

Mailing Address: _____ Fax: ( )

Apt. _____

E-Mail: _____

Floor _____

City: _____ Contact Name: _____

State Zip

County/Borough: _____ Contact Phone: ( )

Partners

List the names, titles, home addresses and phone numbers of all legal partners

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

(Continued on next page)

Business Information (continued)

Legal Information (continued)

Applicant Name:

☐ **Limited Liability Company (LLC)**

LLC Name: _____ DBA: _____

Federal ID: ☐☐-☐☐☐☐☐☐☐

Mailing Address: _____ Fax: ( )

Apt.

_____ E-Mail: _____

Floor

City: _____ Contact Name: _____

State Zip

County/Borough: _____ Contact Phone: ( )

Board Member

List the name, title, home address and phone number of a Board Member of the corporation

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

(Continued on reverse side)

Tear Here

Business Information (continued)

Legal Information (continued)

☐ Unincorporated Association

Legal Name: _____ DBA: _____

Federal ID: ☐☐-☐☐☐☐☐☐☐

Mailing Address: _____ Fax: ( )

Apt.

_____ E-Mail: _____

Floor

City: _____ Contact Name: _____

State Zip

County/Borough: _____ Contact Phone: ( )

Members

List the names, titles, home addresses and phone numbers of all members

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

Name: _____ Title: _____

Last First MI

Address: _____ Phone: ( )

Street City State/Zip

SSN: ☐☐☐-☐☐-☐☐☐☐ **OR** Federal ID: ☐☐-☐☐☐☐☐☐☐

Requirements

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CPR & First Aid Requirement

INSTRUCTIONS

Submit

Maintain On-Site

- *Review the requirements listed below and complete the lower section with the names of all individuals that are certified in CPR and/or First Aid*
- *Attach additional sheets if necessary*
- *A copy of each certification must be retained on-site at all times and available for review*
- *Please PRINT clearly*

Applicant Name:	Program Name:

Requirement

- All programs are required to have at least one caregiver who holds a valid certificate in cardiopulmonary resuscitation (CPR) and first aid, present at the child care program during the program's operating hours.
- Care cannot be provided unless the person(s) with these certifications are present.
- Online certifications that require a demonstration of skills are permitted in some circumstances. Please consult with your licensor/registrar prior to training.

Certifications (List everyone with a certification)

Name	Certification	Expiration Date(s)
	☐ CPR	
	☐ First Aid	
	☐ CPR	
	☐ First Aid	
	☐ CPR	
	☐ First Aid	
	☐ CPR	
	☐ First Aid	
	☐ CPR	
	☐ First Aid	

Provider Signature: _____ Date: ____/____/____
(mm / dd / yyyy)

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This page was intentionally left blank so that the instructions and the form would be side-by-side.

Guidelines for Fingerprinting

Do NOT Get Fingerprinted Until Your Application Has Been Submitted

BEFORE COMPLETING the Request for NYS Fingerprinting Services form, please make additional copies for each person to be fingerprinted for your program. Consider keeping a blank copy of the form on site.

Fingerprinting is required for the Owner/Operator, Director, Provider, Site Supervisor, Household Members age 18 and over, Assistants, Substitutes as well as all Employees and Volunteers in accordance with New York State law and OCFS child care regulations.

PLEASE NOTE: Fingerprint cards have been replaced with an automated fingerprint imaging process.

1. ***Anyone who has been previously fingerprinted by OCFS*** for the purposes of child day care or foster care or adoption approval, may not need to be fingerprinted again. You may instead be eligible for a waiver. Contact your licensor or registrar before continuing.

2. If anyone has not been fingerprinted by OCFS before, you must go to an authorized digital imaging center in New York State.
   - Complete the Request for NYS Fingerprinting Services form on the next page;
   - Schedule an appointment by calling 1-877-472-6915 or by going to the following website: http://www.identogo.com/FP/NewYork.aspx.
   - You can select the location for your fingerprinting when you schedule your appointment.

3. The Request for NYS Fingerprinting Services Form must be completed accurately with no blank fields. Use the information from this form when making the appointment. When being fingerprinted for child day care purposes, please disregard the foster care/adoption fields.
   - Make sure that the Facility/Agency ID Number and the Facility Name/Address under the "Contributor Agency Section" are completed correctly. The Facility/Agency ID number is the license/registration number assigned to the program for which you are applying.
   - Each person to be fingerprinted must complete the Applicant section with their own information. For the purposes of this form, "Applicant" means the person to be fingerprinted.
   - Everyone must also select the appropriate role in the Child Day Care/Role of Applicant section.

4. On the day of the fingerprinting appointment:
   - Bring the completed form for each person being fingerprinted. No one will be fingerprinted without this form. There are no blank forms available at the scan location.
   - Each person must bring the appropriate Identification (ID) listed on the back of the form. No one will be fingerprinted without appropriate ID.
   - Your picture may be taken and your identification will be validated.

Additional "Request for NYS Fingerprinting Services" forms (OCFS-4930) are available online at http://ocfs.ny.gov/main/documents/docsChildCare.asp by calling 518-473-0971 (refer to form number OCFS 4930).

If you have additional questions, please contact your licensor or registrar.

NEW YORK STATE
OFFICE OF CHILDREN & FAMILY SERVICES

REQUEST FOR NYS FINGERPRINTING SERVICES

Information Form

(To be completed by Provider or Foster Care/Adoption Agency)

Tear Here

Enrollment Information:

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

Appointments can be obtained by contacting vendor at one of the following:

Website: http://www.identogo.com/FP/NewYork.aspx or the **Call Center**: 877-472-6915

Contributor Agency Section:

ORI: NY922130Z Contributor Agency: NYS Office of Children & Family Services

Job or License Type: ☒ Child Day Care ☐ Foster Care/Adoption ☐ Mentor
☐ OCFS Employee (employee / peace officer – *please circle one*)

Facility/Agency ID Number: _____ Additional Agency ID Info: N/A
(FOSTER CARE/ADOPTION ONLY)

Facility Name/Address: _____

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 Applicant (please check one):

CHILD DAY CARE: ☐ Director ☐ Provider ☐ Employee/Teacher/Volunteer ☐ Household Member over 18 yrs

FOSTER CARE: ☐ Foster Parent ☐ Relative Foster Parent ☐ Household Member over 18 yrs
☐ Foster Child

ADOPTION: ☐ Adoptive Parent ☐ Household Member over 18 yrs

Additional Information: (Foster Care Only)

CONNECTIONS Home Resource ID# N/A

CONNECTIONS Person ID# N/A

Accepted Forms of Identification:

NOTE: Applicant *MUST* present two (2) forms of ID, at least one of which must have a photo (see Column A):

Column A - Valid Photo Identification:	Column B - Valid Supplementary Identification:
U.S. Passport (unexpired or expired) Permanent Resident Card Alien Registration Receipt Card Unexpired Foreign Passport Driver's License or Photo ID Card (issued by U.S. State or Territory) School or College ID Card (with photo) Unexpired Employment Authorization with photo (Form I-766, I-688, I-688A or B) Photo ID Card issued by federal, state, or local govt.	Voter registration card U.S. Military card or draft record Military dependent's ID card Coast Guard Merchant Mariner Card Native American Tribal Document Canadian Driver's License U.S. Social Security Card Original or certified copy of a Birth Certificate issued by authorized U.S. agency with official seal Certification of Birth Abroad (issued by U.S. Department of State) U.S. Citizen ID Card (Form I-7)

Identification if under 18 and nothing else available:

School record or report card
Clinic, doctor, or hospital record

Enrollment Website address: http://www.identogo.com/FP/NewYork.aspx

Call Center phone number: 877-472-6915

Provider Qualifications

INSTRUCTIONS

Submit

- *This form should be completed by the primary child care provider*
- *Fill in all areas that apply, or attach a resume*
- *For your assistance, we have added examples*
- *Please PRINT clearly*

Applicant Name:

Minimum Requirements

You must have EITHER (Check one):

☐ 2 years of paid or unpaid experience caring for children under 6 years of age (including your own)
OR

☐ 1 year of paid or unpaid experience caring for children under 6 years of age and 6 hours of training or education in early childhood development.

Child Care Experience

EXAMPLE:	Date Range	Description	Location
	2006 - Present	Parenting	In my home

Date Range	Description	Location

Relevant Training

EXAMPLE:	Date Received	Description	Hours	Sponsoring Organization
	June, 2010	Child Development Workshop	4	Child Care Council

Date Received	Description	Hours	Sponsoring Organization

Additional Qualifications

(Optional)

EXAMPLE:	Date(s)	Type	Issued By
	May 2012	EMT	Town of Colonie

Date(s)	Type	Issued By

Orientation Completed

I have completed the OCFS approved orientation session

☐ Yes ☐ No ☐ Not Applicable

Health & Safety Training

☐ I have completed the required Health and Safety Training. (A copy of the certificate of completion must be sent to your licensor/registrar.)

☐ I am scheduled to take the required Health and Safety Training on: __ / __ / _____
(mm / dd / yyyy)

Tear Here

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Provider References

INSTRUCTIONS

Submit

- *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 your previous employer as one of your references*
- *Please PRINT clearly*

Applicant Name:

Reference #1

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name:
Last First MI

Business Name:

Address: Apt:

Floor:

City: State: Zip: Daytime Phone: ( )

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

Reference #2

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name:
Last First MI

Business Name:

Address: Apt:

Floor:

City: State: Zip: Daytime Phone: ( )

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:

Address: Apt:

Floor:

City: State: Zip: Daytime Phone: ( )

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

Tear Here

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Frequently Asked Questions

When Completing the SCR (LDSS-3370) Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE STATE CENTRAL REGISTER.

1. **Is a fee required to process a facility's SCR Clearances?**

   Yes, a fee of $25 is required to process the SCR clearance forms. Refer to the "SCR Processing Fee" page in the appendix for more information.

2. **Where do I start?**

   The "Applicant/Household Member Area" section is where you start to fill out the form. The person completing the form is considered the "Applicant" for SCR purposes. Do NOT write in the area above the Applicant/Household Member Area section.

3. **Who do I list on this form?**

   In the Applicant/Household Member Area, place your name that you are known by now on the "APPLICANT" line. If your birth name is different, place that name on the "MAIDEN/ALIAS" line. If you are known by other, additional names place them on the lines below "MAIDEN/ALIAS" and list the "Relationship to Applicant" as "SELF."

   Next, name all adults and children who currently live in the household (including college students who stay in your home during college breaks). This should be everyone you listed on the General Information on page A-3. Include in the first column the relationship to you, the applicant. Examples of relationships are: Spouse, Daughter, Son, Friend, Boarder, Grandmother, etc. Also enter the sex and date of birth for each person that you include.

   If you need more space than is provided on the first page, use the "Statewide Central Register Database Check Form Additional Page" sheet under the "Other Household Members" heading to record the remainder of the people in your household.

4. **What if I have never been known by another name?**

   If you have never been known by another name, write "NONE" in the Last Name field column in the "MAIDEN/ALIAS" line.

5. **Is a prior married name an alias?**

   Yes. Please be aware that all married name(s) are considered aliases, even if you are no longer known by that name. This includes hyphenated names.

6. **Do I need to complete the Applicant/Household Member Area even if I live alone?**

   Yes. If you live alone, write the words "LIVE ALONE" on the first available line.

7. **What if I cannot remember the full address of everywhere I have lived for the last 28 years?**

   An address history must be provided for EVERY adult listed in the Applicant/Household Member Area section. Furthermore, the address history for each adult cannot have ANY gaps in the dates. The State Central Registry will REJECT your form if a street address for each adult has not been entered for the entire time period.

   As best as you can, record the actual house and/or apartment number and street/route address, city, state and zip or country. For each address line, record the time period they lived there in a month/year format. If you need additional space, use the "Statewide Central Register Database Check Form Additional Page" sheet to write the additional addresses.

8. **When do all adults need to sign this form?**

   When the residence of the person filling out this form will be used for providing care, all adults who reside in the household need to sign this form. If there are not enough lines for all the adults, sign in the blank space at the bottom of the page.

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/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. 04/2009) 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

Tear Here

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)*
- **J** - Over 18 Household Member (with no child care role)
- **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 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.

**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.

SUBMIT YOUR COMPLETED LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED $25 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/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.

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

Tear Here

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LDSS-3370 (Rev. 04/2009)

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

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This page was intentionally left blank so that the instructions and the form would be side-by-side.

Frequently Asked Questions

When Completing the Staff Exclusion List (SEL) Check Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE JUSTICE CENTER

1. **Who needs a Justice Center Staff Exclusion List (SEL) check?**

   In general, if you are required to get an SCR database check, you also need to get an SEL check. This includes:

   - Applicants to become family or group family child care providers
   - Household members age 18 and over in family or group family day care homes
   - Directors of day care centers or school age child care programs
   - All new employees of licensed or registered child care programs

2. **What is the SEL?**

   The SEL is a list of persons, who are former employees of programs serving people with special needs, who have committed an act of abuse or neglect regarding those service recipients. The process to get an SEL check is similar to the process to get a Statewide Central Register (SCR) database check. It does not replace the SCR process.

3. **What portion of the form do I fill out?**

   ONLY complete Part 1 Applicant Information.

4. **Is a fee required to process my Request for Staff Exclusion List (SEL) Check form?**

   No, this database check is free.

5. **What if my name appears on the SEL?**

   An evaluation will be conducted on the substantiated findings to determine what impact, if any, inclusion on the SEL may have on the child care program.

6. **While I am waiting for the results, can I be left alone with day care children?**

   No. All background checks, including the SEL, must be completed before a new provider or employee can be left unsupervised with children.

7. **What if I have additional questions?**

   Call your licensor/registrar.

NYS Justice Center For the Protection of People with Special Needs	**Request for Staff Exclusion List (SEL) Check Form** For OCFS Family, Group Family, Small Day Care Providers, Day Care Center and School Age Child Care Programs	NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit Fax: 518-549-0464

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 children in child care programs.

Instructions:

1. **Family, group family, and small day care center providers**: For all provider and staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children, including residents in the home over 18 years of age, the provider must complete this form and send it to their licensor/registrar who will submit it to the Justice Center's Criminal Background Check (CBC) unit.
2. **Day care center and school age child care directors:** For all staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children in the program, the program's Authorized Person must complete this form and fax it to the Justice Center's CBC unit. A Director's SEL background check must be forwarded to the OCFS licensor for submission to the CBC.
3. The licensor/registrar or program's Authorized Person will be sent an email indicating the results of the SEL check.
4. If the Applicant is on the SEL, the licensor or registrar or program shall determine whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Tear Here

Part 1. Applicant Information (Please type or print clearly)

Last Name:	First Name:	MI:
Social Security Number:	Alien Reg. Number: *If no SSN is available*	
Job Title:	Date of Birth: *Only if no SSN or Alien Reg. is available*	
Program Name & Address:		
License or registration number:		

Part 2. Authorized Person Information – OFFICE USE ONLY

Name:		**Work Email:**
Facility/Provider Name:		**Phone:**
License or registration number:		

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Provider Medical Statement

INSTRUCTIONS

Submit

Maintain On-Site

- *A signature is required on **BOTH PAGES** of this form*
- *Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section*
- ***A registered nurse is NOT authorized to sign the Medical Condition section***
- *A health care provider may use an equivalent form as long as the information on this form is included*

Applicant Name:	Date of Birth:

Typical Provider Duties

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

Following to be completed by Health Professional ONLY

Medical Condition

Date of Exam ____/____/_____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is physically fit to provide child day care and perform the duties listed above. ☐ **YES** ☐ **NO**

For any "No" responses, indicate restrictions: _____

_____

_____

_____

Signature *(physician, physician's assistant, nurse practitioner)*	
Name *(Please PRINT clearly or use office stamp)*	**Title**
( ) -	**/ /**
Phone	**Date**

(Continued on reverse side)

Tear Here

Provider Medical Statement (continued)

INSTRUCTIONS


Submit


Maintain On File

- *A health care provider (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 TB section and sign this page*
- *Acceptable TB tests include Mantoux or other federally approved tuberculin test*
- *Please PRINT clearly*

Applicant Name:	Date of Birth:

Following to be completed by Health Professional ONLY

Tuberculin Test Information

Test Completed

Test Read on: _____
(mm / dd / yyyy)

If test result was previously Positive, indicate date: _____
(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)

Signature *(physician, physician's assistant, nurse practitioner OR a registered nurse)*	
Name *(Please PRINT clearly or use office stamp)*	**Title**
( ) - **Phone**	**/ /** **Date**

Provider Criminal Conviction Statement

INSTRUCTIONS

Submit

- *All applicants must complete and sign this form regardless of conviction status*
- *This form is in addition to being fingerprinted*
- *Attach additional pages as necessary*
- *Please PRINT clearly*

Applicant Name:

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	12/07/1966	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.

Type of Crime	**Penal Code Section** (if known)	**Date of Conviction** (mm / dd / yyyy)	**County or Court of Arraignment**
		/ /	
		/ /	
		/ /	
		/ /	

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)

Tear Here

Provider Conviction Statement (continued)

Applicant Name:

Please provide your justification below, explaining why you should be allowed to care for children despite your conviction. You may attach your own sheets if you prefer not to use this page.

Assistant Information

INSTRUCTIONS

Submit

- *At least ONE Assistant is REQUIRED and must complete this form*
- *Additional Assistants should complete the Additional Caregiver forms that follow this section*
- *Each caregiver must be fingerprinted and complete: Qualifications, References, State Central Register Database Check form, Staff Exclusion List Check, a Criminal Conviction Statement and a Medical Statement*
- *Please PRINT clearly*

Applicant Name:	Facility Name:
	Assistant Name:

Identifying Information

☐Mr. ☐Mrs. ☐Ms.

Name:
Last First MI

Mailing Address: Apt:

Floor:

City: State: Zip:

Home Phone: ( ) E-Mail:

Date of Birth: / /
(mm / dd / yyyy)

Tear Here

- I certify that I am 18 years of age or older.
- I have received and read, and I understand New York State Office of Children and Family Services regulations for the operation of a group family day care home. I will be in compliance with these regulations.
- I understand that I must report to the State Central Register (1-800-635-1522) any incidents of suspected child abuse or maltreatment concerning any child in my care.
- To the best of my knowledge, all of the information I have entered on the forms required to become an Assistant is true and accurate.

Assistant Signature: _____ Date: / /
(mm / dd / yyyy)

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Assistant Qualifications

INSTRUCTIONS

Submit

- *At least ONE Assistant is REQUIRED and must complete this form*
- *Additional Assistants should complete the Additional Caregiver forms that follow this section*
- *Fill in all areas that apply, or attach a resume*
- *Please PRINT clearly*

Applicant Name:	
Assistant Name:	Date of Birth:

Minimum Requirements

You must have EITHER (Check one):

☐ 2 years of paid or unpaid experience caring for children under 6 years of age (including your own)
OR

☐ 1 year of paid or unpaid experience caring for children under 6 years of age and 6 hours of training or education in early childhood development.

Child Care Experience

EXAMPLE:	Date Range	Description	Location
	2006 - Present	Camp Counselor	Community Center

Date Range	Description	Location

Relevant Training

EXAMPLE:	Date Received	Description	Hours	Sponsoring Organization
	June, 2010	Child Development Workshop	4	Child Care Council

Date Received	Description	Hours	Sponsoring Organization

Additional Qualifications

(Optional)

EXAMPLE:	Date(s)	Type	Issued By
	May 2012	EMT	Town of Colonie

Date(s)	Type	Issued By

Tear Here

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Assistant References

INSTRUCTIONS

Submit

- *At least ONE Assistant is REQUIRED and must complete this form*
- *Additional Assistants should complete the Additional Caregiver forms that follow this section*
- *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*

Applicant Name:	
Assistant Name:	Date of Birth:

Reference #1

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name: _____
Last First MI

Business Name: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

Does reference speak English? ☐**Yes** ☐**No** If no, please specify language spoken: _____

Reference #2

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name: _____
Last First MI

Business Name: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

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: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

Does reference speak English? ☐**Yes** ☐**No** If no, please specify language spoken: _____

Tear Here

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Frequently Asked Questions

When Completing the SCR (LDSS-3370) Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE STATE CENTRAL REGISTER.

1. **Is a fee required to process a facility's SCR Clearances?**

   Yes, a fee of $25 is required to process the SCR clearance forms. Refer to the "SCR Processing Fee" page in the appendix for more information.

2. **Where do I start?**

   The "Applicant/Household Member Area" section is where you start to fill out the form. The person completing the form is considered the "Applicant" for SCR purposes. Do NOT write in the area above the Applicant/Household Member Area section.

3. **Who do I list on this form?**

   In the Applicant/Household Member Area, place your name that you are known by now on the "APPLICANT" line. If your birth name is different, place that name on the "MAIDEN/ALIAS" line. If you are known by other, additional names place them on the lines below "MAIDEN/ALIAS" and list the "Relationship to Applicant" as "SELF."

   Next, name all adults and children who currently live in the household (including college students who stay in your home during college breaks). This should be everyone you listed on the General Information on page A-3. Include in the first column the relationship to you, the applicant. Examples of relationships are: Spouse, Daughter, Son, Friend, Boarder, Grandmother, etc. Also enter the sex and date of birth for each person that you include.

   If you need more space than is provided on the first page, use the "Statewide Central Register Database Check Form Additional Page" sheet under the "Other Household Members" heading to record the remainder of the people in your household.

4. **What if I have never been known by another name?**

   If you have never been known by another name, write "NONE" in the Last Name field column in the "MAIDEN/ALIAS" line.

5. **Is a prior married name an alias?**

   Yes. Please be aware that all married name(s) are considered aliases, even if you are no longer known by that name. This includes hyphenated names.

6. **Do I need to complete the Applicant/Household Member Area even if I live alone?**

   Yes. If you live alone, write the words "LIVE ALONE" on the first available line.

7. **What if I cannot remember the full address of everywhere I have lived for the last 28 years?**

   An address history must be provided for EVERY adult listed in the Applicant/Household Member Area section. Furthermore, the address history for each adult cannot have ANY gaps in the dates. The State Central Registry will REJECT your form if a street address for each adult has not been entered for the entire time period.

   As best as you can, record the actual house and/or apartment number and street/route address, city, state and zip or country. For each address line, record the time period they lived there in a month/year format. If you need additional space, use the "Statewide Central Register Database Check Form Additional Page" sheet to write the additional addresses.

8. **When do all adults need to sign this form?**

   When the residence of the person filling out this form will be used for providing care, all adults who reside in the household need to sign this form. If there are not enough lines for all the adults, sign in the blank space at the bottom of the page.

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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/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. 04/2009) 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

Tear Here

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)*
- **J** - Over 18 Household Member (with no child care role)
- **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 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.

**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.

SUBMIT YOUR COMPLETED LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED $25 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/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.

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

Tear Here

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LDSS-3370 (Rev. 04/2009)

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

Tear Here

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This page was intentionally left blank so that the instructions and the form would be side-by-side.

Frequently Asked Questions

When Completing the Staff Exclusion List (SEL) Check Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE JUSTICE CENTER

1. **Who needs a Justice Center Staff Exclusion List (SEL) check?**

   In general, if you are required to get an SCR database check, you also need to get an SEL check. This includes:

   - Applicants to become family or group family child care providers
   - Household members age 18 and over in family or group family day care homes
   - Directors of day care centers or school age child care programs
   - All new employees of licensed or registered child care programs

2. **What is the SEL?**

   The SEL is a list of persons, who are former employees of programs serving people with special needs, who have committed an act of abuse or neglect regarding those service recipients. The process to get an SEL check is similar to the process to get a Statewide Central Register (SCR) database check. It does not replace the SCR process.

3. **What portion of the form do I fill out?**

   ONLY complete Part 1 Applicant Information.

4. **Is a fee required to process my Request for Staff Exclusion List (SEL) Check form?**

   No, this database check is free.

5. **What if my name appears on the SEL?**

   An evaluation will be conducted on the substantiated findings to determine what impact, if any, inclusion on the SEL may have on the child care program.

6. **While I am waiting for the results, can I be left alone with day care children?**

   No. All background checks, including the SEL, must be completed before a new provider or employee can be left unsupervised with children.

7. **What if I have additional questions?**

   Call your licensor/registrar.

	**Request for Staff Exclusion List (SEL) Check Form** For OCFS Family, Group Family, Small Day Care Providers, Day Care Center and School Age Child Care Programs	NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit Fax: 518-549-0464

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 children in child care programs.

Instructions:

1. **Family, group family, and small day care center providers**: For all provider and staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children, including residents in the home over 18 years of age, the provider must complete this form and send it to their licensor/registrar who will submit it to the Justice Center's Criminal Background Check (CBC) unit.
2. **Day care center and school age child care directors:** For all staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children in the program, the program's Authorized Person must complete this form and fax it to the Justice Center's CBC unit. A Director's SEL background check must be forwarded to the OCFS licensor for submission to the CBC.
3. The licensor/registrar or program's Authorized Person will be sent an email indicating the results of the SEL check.
4. If the Applicant is on the SEL, the licensor or registrar or program shall determine whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Part 1. Applicant Information (Please type or print clearly)

Last Name:	First Name:	MI:
Social Security Number:	Alien Reg. Number: *If no SSN is available*	
Job Title:	Date of Birth: *Only if no SSN or Alien Reg. is available*	
Program Name & Address:		
License or registration number:		

Part 2. Authorized Person Information – OFFICE USE ONLY

Name:		**Work Email:**
Facility/Provider Name:		**Phone:**
License or registration number:		

JC CBC #15 (12/13)

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Assistant Medical Statement

INSTRUCTIONS

Submit

Maintain On-Site

- *At least ONE Assistant is REQUIRED and must complete this form*
- *A signature is required on **BOTH PAGES** of this form*
- *Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section*
- ***A registered nurse is NOT authorized to sign the Medical Condition section***
- *A health care provider may use an equivalent form as long as the information on this form is included*
- *Please PRINT clearly*

Applicant Name:	
Assistant Name:	Date of Birth:

Typical Caregiver Duties

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

Following to be completed by Health Professional ONLY

Medical Condition

Date of Exam ____/____/_____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is physically fit to provide child day care and perform the duties listed above. ☐ **YES** ☐ **NO**

For any "No" responses, indicate restrictions: _____

_____

_____

_____

Signature *(physician, physician's assistant, nurse practitioner)*	
Name *(Please PRINT clearly or use office stamp)*	**Title**
( ) -	**/ /**
Phone	**Date**

(Continued on reverse side)

Tear Here

Assistant Medical Statement (cont.)

INSTRUCTIONS


Submit


Maintain On File

- *A health care provider (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 TB section and sign this page*
- *Acceptable TB tests include Mantoux or other federally approved tuberculin test*
- *Please PRINT clearly*

Applicant Name:	
Assistant Name:	Date of Birth:

Following to be completed by Health Professional ONLY

Tuberculin Test Information

Test Completed

Test Read on: _____
(mm / dd / yyyy)

If test result was previously Positive, indicate date: _____
(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)

Signature *(physician, physician's assistant, nurse practitioner OR a registered nurse)*	
Name *(Please PRINT clearly or use office stamp)*	**Title**
( ) - **Phone**	**/ /** **Date**

Assistant Criminal Conviction Statement

INSTRUCTIONS

Submit

- *At least ONE Assistant is REQUIRED and must complete this form regardless of conviction status*
- *This form is in addition to being fingerprinted*
- *Attach additional pages as necessary*
- *Please PRINT clearly*

Applicant Name:	Assistant Name:

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	12/07/1966	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.

Type of Crime	**Penal Code Section** (if known)	**Date of Conviction** (mm / dd / yyyy)	**County or Court of Arraignment**
		/ /	
		/ /	
		/ /	
		/ /	

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)

Tear Here

Assistant Conviction Statement (continued)

Applicant Name:	Assistant Name:

Please provide your justification below, explaining why you should be allowed to care for children despite your conviction. You may attach your own sheets if you prefer not to use this page.

Additional Caregiver Information

INSTRUCTIONS

Submit

Maintain On-Site

- *Additional caregivers are not required, but a program may have as many as needed*
- *All caregivers must complete this form; duplicate as needed*
- *Household Members who will function as a caregiver must complete this form*
- *Each caregiver must be fingerprinted and complete: Qualifications, References, State Central Register Database Check form, Staff Exclusion List Check, Criminal Conviction Statement and a Medical Statement*
- *Please PRINT clearly*

Applicant Name:

Additional Caregivers

An **Assistant** is any person who has been selected by you to regularly provide child day care to children in your program.

A **Substitute** is someone who provides care during short term, non-recurring absences of the On-site Provider or Assistant(s).

All caregivers must be age 18 or over. Additional restrictions exist for both roles; contact your licensor/registrar for additional information.

No one can be left alone with day care children without written approval for their role from this Office.

Tear Here

Identifying Information for: ☐ Assistant ☐ Substitute (Check one)

☐Mr. ☐Mrs. ☐Ms.

Name: _____
Last First MI

Mailing Address: _____ Apt: _____

Floor: _____

City: _____ State: _____ Zip: _____

Home Phone: ( ) E-Mail: _____

Date of Birth: / /
(mm / dd / yyyy)

- I certify that I am 18 years of age or older.
- I have received and read, and I understand New York State Office of Children and Family Services regulations for the operation of the child day care program. I will be in compliance with these regulations.
- I understand that I must report to the State Central Register (1-800-635-1522) any incidents of suspected child abuse or maltreatment concerning any child in my care.
- To the best of my knowledge, all of the information I have entered on the forms required is true and accurate.

Signature: _____ Date: / /
(mm / dd / yyyy)

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Additional Caregiver Qualifications

INSTRUCTIONS

Submit

- *All additional caregivers must complete this form; duplicate as needed*
- *Fill in all areas that apply, or attach a resume*
- *For your assistance, we have added examples*
- *Please PRINT clearly*

Applicant Name:	
Caregiver Name:	Date of Birth:

Minimum Requirements

You must have EITHER (Check one):

☐ 2 years of paid or unpaid experience caring for children under 6 years of age (including your own)
OR

☐ 1 year of paid or unpaid experience caring for children under 6 years of age and 6 hours of training or education in early childhood development.

Child Care Experience

EXAMPLE:	Date Range	Description	Location
	2006 - Present	Camp Counselor	Community Center

Date Range	Description	Location

Relevant Training

EXAMPLE:	Date Received	Description	Hours	Sponsoring Organization
	June, 2010	Child Development Workshop	4	Child Care Council

Date Received	Description	Hours	Sponsoring Organization

Additional Qualifications

(Optional)

EXAMPLE:	Date(s)	Type	Issued By
	May 2012	EMT	Town of Colonie

Date(s)	Type	Issued By

Tear Here

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Additional Caregiver References

INSTRUCTIONS

Submit

- *All additional caregivers must complete this form; duplicate as needed*
- *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*

Applicant Name:	
Caregiver Name:	Date of Birth:

Reference #1

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name: _____
Last First MI

Business Name: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

Does reference speak English? ☐**Yes** ☐**No** If no, please specify language spoken: _____

Reference #2

Please check appropriate reference type: ☐ Personal ☐ Employment

☐Mr. ☐Mrs. ☐Ms. Name: _____
Last First MI

Business Name: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

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: _____

Address: _____ Apt: _____

Floor: _____

City: _____ State: Zip: Daytime Phone: ( )

Does reference speak English? ☐**Yes** ☐**No** If no, please specify language spoken: _____

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Frequently Asked Questions

When Completing the SCR (LDSS-3370) Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE STATE CENTRAL REGISTER.

1. **Is a fee required to process a facility's SCR Clearances?**

   Yes, a fee of $25 is required to process the SCR clearance forms. Refer to the "SCR Processing Fee" page in the appendix for more information.

2. **Where do I start?**

   The "Applicant/Household Member Area" section is where you start to fill out the form. The person completing the form is considered the "Applicant" for SCR purposes. Do NOT write in the area above the Applicant/Household Member Area section.

3. **Who do I list on this form?**

   In the Applicant/Household Member Area, place your name that you are known by now on the "APPLICANT" line. If your birth name is different, place that name on the "MAIDEN/ALIAS" line. If you are known by other, additional names place them on the lines below "MAIDEN/ALIAS" and list the "Relationship to Applicant" as "SELF."

   Next, name all adults and children who currently live in the household (including college students who stay in your home during college breaks). This should be everyone you listed on the General Information on page A-3. Include in the first column the relationship to you, the applicant. Examples of relationships are: Spouse, Daughter, Son, Friend, Boarder, Grandmother, etc. Also enter the sex and date of birth for each person that you include.

   If you need more space than is provided on the first page, use the "Statewide Central Register Database Check Form Additional Page" sheet under the "Other Household Members" heading to record the remainder of the people in your household.

4. **What if I have never been known by another name?**

   If you have never been known by another name, write "NONE" in the Last Name field column in the "MAIDEN/ALIAS" line.

5. **Is a prior married name an alias?**

   Yes. Please be aware that all married name(s) are considered aliases, even if you are no longer known by that name. This includes hyphenated names.

6. **Do I need to complete the Applicant/Household Member Area even if I live alone?**

   Yes. If you live alone, write the words "LIVE ALONE" on the first available line.

7. **What if I cannot remember the full address of everywhere I have lived for the last 28 years?**

   An address history must be provided for EVERY adult listed in the Applicant/Household Member Area section. Furthermore, the address history for each adult cannot have ANY gaps in the dates. The State Central Registry will REJECT your form if a street address for each adult has not been entered for the entire time period.

   As best as you can, record the actual house and/or apartment number and street/route address, city, state and zip or country. For each address line, record the time period they lived there in a month/year format. If you need additional space, use the "Statewide Central Register Database Check Form Additional Page" sheet to write the additional addresses.

8. **When do all adults need to sign this form?**

   When the residence of the person filling out this form will be used for providing care, all adults who reside in the household need to sign this form. If there are not enough lines for all the adults, sign in the blank space at the bottom of the page.

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/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. 04/2009) 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

Tear Here

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)*
- **J** - Over 18 Household Member (with no child care role)
- **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 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.

**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.

SUBMIT YOUR COMPLETED LDSS-3370 FORM TO YOUR LICENSOR OR REGISTRAR
BE SURE TO INCLUDE THE REQUIRED $25 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/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.

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

Tear Here

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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

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This page was intentionally left blank so that the instructions and the form would be side-by-side.

Frequently Asked Questions

When Completing the Staff Exclusion List (SEL) Check Form

MAIL THESE FORMS TO THE PERSON ASSISTING YOU WITH YOUR APPLICATION AND NOT TO THE JUSTICE CENTER

1. **Who needs a Justice Center Staff Exclusion List (SEL) check?**

   In general, if you are required to get an SCR database check, you also need to get an SEL check. This includes:

   - Applicants to become family or group family child care providers
   - Household members age 18 and over in family or group family day care homes
   - Directors of day care centers or school age child care programs
   - All new employees of licensed or registered child care programs

2. **What is the SEL?**

   The SEL is a list of persons, who are former employees of programs serving people with special needs, who have committed an act of abuse or neglect regarding those service recipients. The process to get an SEL check is similar to the process to get a Statewide Central Register (SCR) database check. It does not replace the SCR process.

3. **What portion of the form do I fill out?**

   ONLY complete Part 1 Applicant Information.

4. **Is a fee required to process my Request for Staff Exclusion List (SEL) Check form?**

   No, this database check is free.

5. **What if my name appears on the SEL?**

   An evaluation will be conducted on the substantiated findings to determine what impact, if any, inclusion on the SEL may have on the child care program.

6. **While I am waiting for the results, can I be left alone with day care children?**

   No. All background checks, including the SEL, must be completed before a new provider or employee can be left unsupervised with children.

7. **What if I have additional questions?**

   Call your licensor/registrar.

NYS Justice Center For the Protection of People with Special Needs	**Request for Staff Exclusion List (SEL) Check Form** For OCFS Family, Group Family, Small Day Care Providers, Day Care Center and School Age Child Care Programs	NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit Fax: 518-549-0464

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 children in child care programs.

Instructions:

1. **Family, group family, and small day care center providers**: For all provider and staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children, including residents in the home over 18 years of age, the provider must complete this form and send it to their licensor/registrar who will submit it to the Justice Center's Criminal Background Check (CBC) unit.
2. **Day care center and school age child care directors:** For all staff applicants under serious consideration to be hired or otherwise permitted to have regular and substantial contact with children in the program, the program's Authorized Person must complete this form and fax it to the Justice Center's CBC unit. A Director's SEL background check must be forwarded to the OCFS licensor for submission to the CBC.
3. The licensor/registrar or program's Authorized Person will be sent an email indicating the results of the SEL check.
4. If the Applicant is on the SEL, the licensor or registrar or program shall determine whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Tear Here

Part 1. Applicant Information (Please type or print clearly)

Last Name:	First Name:	MI:
Social Security Number:	Alien Reg. Number: *If no SSN is available*	
Job Title:	Date of Birth: *Only if no SSN or Alien Reg. is available*	
Program Name & Address:		
License or registration number:		

Part 2. Authorized Person Information – OFFICE USE ONLY

Name:		**Work Email:**
Facility/Provider Name:		**Phone:**
License or registration number:		

JC CBC #15 (12/13)

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Caregiver Medical Statement

INSTRUCTIONS

Submit

Maintain On-Site

- ***All** additional caregivers must complete this form; duplicate as needed*
- *A signature is required on **BOTH PAGES** of this form*
- *Only a health care provider (physician, physician's assistant, nurse practitioner) may complete and sign the Medical Condition section*
- ***A registered nurse is <u>NOT</u> authorized to sign the Medical Condition section***
- *A health care provider may use an equivalent form as long as the information on this form is included*
- *Please PRINT clearly*

Applicant Name:	
Caregiver Name:	Date of Birth:

Typical Caregiver Duties

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

Following to be completed by Health Professional <u>ONLY</u>

Medical Condition

Date of Exam ____/____/_____

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted during day care. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children. ☐ **YES** (symptom free) ☐ **NO** (NOT symptom free)
- He/she is physically fit to provide child day care and perform the duties listed above. ☐ **YES** ☐ **NO**

For any "No" responses, indicate restrictions: _____

_____

_____

_____

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

Name *(Please PRINT clearly or use office stamp)* **Title**

( ) - / /

Phone **Date**

(Continued on reverse side)

Tear Here

Caregiver Medical Statement (continued)

INSTRUCTIONS


Submit


Maintain On File

- *A health care provider (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 TB section and sign this page*
- *Acceptable TB tests include Mantoux or other federally approved tuberculin test*
- *Please PRINT clearly*

Applicant Name:	
Caregiver Name:	Date of Birth:

Tuberculin Test Information

Test Completed

Test Read on: _____
(mm / dd / yyyy)

If test result was previously Positive, indicate date: _____
(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)

Signature *(physician, physician's assistant, nurse practitioner OR a registered nurse)*	
Name *(Please PRINT clearly or use office stamp)*	**Title**
( ) -	**/ /**
Phone	**Date**

Caregiver Criminal Conviction Statement

INSTRUCTIONS

Submit

- *All additional caregivers must complete and sign this form regardless of conviction status*
- *This form is in addition to being fingerprinted*
- *Attach additional pages as necessary*
- *Please PRINT clearly*

Applicant Name:	Caregiver Name:

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	12/07/1966	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.

Type of Crime	**Penal Code Section** (if known)	**Date of Conviction** (mm / dd / yyyy)	**County or Court of Arraignment**
		/ /	
		/ /	
		/ /	
		/ /	

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)

Tear Here

Caregiver Conviction Statement (continued)

Applicant Name:	Caregiver Name:

Please provide your justification below, explaining why you should be allowed to care for children despite your conviction. You may attach your own sheets if you prefer not to use this page.

Household Member Medical Statement

INSTRUCTIONS

Submit **Maintain On-Site**

- *Each person residing in the home must have a signed medical statement; if the Household Member will be an Assistant or Substitute, a different form is required*
- *One health care provider (Physician, Physician's Assistant or Nurse Practitioner) may sign for multiple household members who are under their care*
- *A health care provider may use an equivalent form as long as the information on this form is included*
- *You may duplicate this form as necessary*

Applicant Name:

Household Members Examined by: _____

Household Members' Names			Date of Birth	Symptom Free*
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No

I have examined the ___ **(1, 2 or 3)** individuals named above, and attest to the findings listed for each person.

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

Name *(Please PRINT or use office stamp)* **Title** ( ) - **Phone**

Household Members Examined by: _____

Household Members' Names			Date of Birth	Symptom Free*
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No
Last	First	MI	/ / (mm / dd / yyyy)	☐ Yes ☐ No

I have examined the ___ **(1, 2 or 3)** individuals named above, and attest to the findings listed for each person.

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

Name *(Please PRINT or use office stamp)* **Title** ( ) - **Phone**

*The person is free from any health condition that would endanger children receiving child care in the home. Attach documentation for any adverse findings.

Tear Here

This page left blank intentionally.

Household Member Criminal Conviction Statement

INSTRUCTIONS

Submit

- *All household members age 18 and over must complete and sign this form regardless of conviction status. Duplicate as needed*
- *This form is in addition to being fingerprinted*
- *Attach additional pages as necessary*
- *Please PRINT clearly*

Applicant Name:	Household Member Name:

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	12/07/1966	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.

Type of Crime	**Penal Code Section** (if known)	**Date of Conviction** (mm / dd / yyyy)	**County or Court of Arraignment**
		/ /	
		/ /	
		/ /	
		/ /	

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)

Tear Here

Household Member Conviction Statement (continued)

Applicant Name:	Household Member Name:

Please provide your justification below, explaining why you should be allowed to have involvement with children at this home, despite your conviction. You may attach your own sheets if you prefer not to use this page.

Site Information

This page left blank intentionally.

Safety Considerations

INSTRUCTIONS

Submit

- *Special requirements apply to pools, bodies of water, firearms and pets*
- *This form must be completed at time of application and at each renewal*
- *You must notify the Office of any changes regarding the information on this page*

Applicant Name:

Pools and Bodies of Water

Review the following list. Using the checkboxes, indicate whether any of these are present on the site property or any bordering property.

Description	Site Property	Bordering Property
Above-ground pool	☐ Yes ☐ No	☐ Yes ☐ No
Deck with access to a body of water	☐ Yes ☐ No	☐ Yes ☐ No
Drainage or run-off ditch	☐ Yes ☐ No	☐ Yes ☐ No
Hot tub or spa	☐ Yes ☐ No	☐ Yes ☐ No
In-ground swimming pool	☐ Yes ☐ No	☐ Yes ☐ No
On-ground swimming pool (wading or inflatable)	☐ Yes ☐ No	☐ Yes ☐ No
Ornamental pond, bird bath or fountain	☐ Yes ☐ No	☐ Yes ☐ No
Private well	☐ Yes ☐ No	☐ Yes ☐ No
River, stream, creek, pond or lake	☐ Yes ☐ No	☐ Yes ☐ No
Other (specify): _____	☐ Yes ☐ No	☐ Yes ☐ No

Other Items

There are firearms, shotguns, rifles, or ammunition on the premises	☐ Yes ☐ No
There are pets or animals on the premises	☐ Yes ☐ No

Tear Here

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Report of Water Supply Testing

INSTRUCTIONS

Submit

Maintain On-Site

- *All applicants must complete this form regardless of testing requirement*
- *Sites that use a private water supply, well, or spring must have had bacterial, chemical, and physical contamination tests performed within the last 12 months*
- *You must provide evidence of an adequate and safe water supply that complies with state and local laws*
- *Please PRINT clearly*

Applicant Name:	Site Address:

Applicant Section – The applicant must ☑ check the appropriate box and follow the instructions provided.

Water Supply Statement

☐ **No** The child care site **does not** use a private water supply system.
(Water testing is NOT required. Do not complete the remainder of this form.)

☐ **Yes** The child care site **does** use a private water supply system.
(Water testing is required by an Approved Water Testing Authority/Inspector.)

Note to Applicant: If the **UNSATISFACTORY** box is checked below, follow the instructions as listed:

- Contact the County Health Department for instructions (consult your local directory)
- Explain their instructions and your plan for implementing them to provide safe drinking water at your site
- Attach any written correspondence from your County Health Department or other testing source

Water Testing Authority Section – An approved water testing authority must complete the section below or attach the test results.

Contact one of the following to submit a water sample for testing.

- *County Health Department*
- *Local Water District or Department*
- *Cooperative Extension*
- *Private Testing Laboratories*

Please read the following statement and ☑ check the appropriate box.

The water supply has been tested in accordance with health standards and is found to be:

☐ **SATISFACTORY** ☐ **UNSATISFACTORY**

Type of Supply Inspected: _____ Inspection Date: / / (mm/dd/yyyy)

Explanation: _____

_____

_____

Signature of Inspector: _____ Telephone: ( )

Name: (Please Print) _____ Address: _____

Agency or Company: _____

_____

Tear Here

This page left blank intentionally.

Fuel Burning System Inspection

INSTRUCTIONS

Submit

Maintain On-Site

- *All applicants must complete this form regardless of inspection requirement*
- *Duplicate and complete this form for each fuel burning system on site*
- *Sites where any wood, coal, pellet, or other solid fuel-burning stove or fireplace, permanently-installed gas space heater or gas fireplace are used at ANY time, must have each of these inspected*
- *Inspections performed within the last 12 months can be attached and submitted with this form*

Applicant Name:	Site Address:

Applicant Section – The applicant must ☑ check the appropriate box and follow the instructions provided.
Inspections are required for:
- Wood, coal, pellet or other solid fuel burning stove or fireplace,
- Permanently-installed gas space heater,
- Gas fireplace, or
- Wood burning furnace or boiler

Tear Here

PLEASE NOTE: The following items do **NOT** require an inspection:

- Water heater
- Kitchen stove
- Gas/Oil/Electric furnace
- Gas/Oil/Electric boiler
- Outside wood boiler

Fuel Burning Statement (CHECK ONE box only)

☐ The site **does not** have a fuel burning system that requires inspection.
Sign below. Do not complete the back of this form.

Applicant Signature: _____ Date: _____ (mm / dd / yyyy)

☐ The site does not **AT ANY TIME** use a fuel burning system that requires inspection.
Sign below. Do not complete the back of this form.

Applicant Signature: _____ Date: _____ (mm / dd / yyyy)

☐ The site **does** use a fuel burning system that requires inspection.

An Inspector must complete the back of this form or attach a report of inspection and approval.

(Continued on reverse side)

Fuel Burning System Inspection (continued)

Inspector Section – An Inspector qualified to approve home fuel burning systems must complete this section.

Contact one of the following:

- Local Fire Marshall or Inspector
- Chimney Sweeps
- Code Enforcement Officials
- Factory Authorized Technician

The fuel burning system has been inspected in accordance with all applicable safety standards:

☐ Has been properly installed or is maintained in compliance with all applicable safety standards

☐ Has not been properly installed or is not maintained in compliance with all applicable safety standards

Type of System Inspected: _____ Inspection Date: ____/____/____ (mm / dd / yyyy)

Explanation: _____

_____

_____

_____ Telephone: (____) _____

Name (Please Print): _____ Address: _____

Title: _____ _____

Agency or Company: _____ _____

_____ _____

Signature of Inspector: _____ **Date**: _____ (mm / dd / yyyy)

This page was intentionally left blank so that the instructions and the form would be side-by-side.

Environmental Hazards Guide

PLEASE READ this guide prior to completing the Environmental Hazards form that follows the guide.

Hazards Summary

All day care applicants and providers are responsible for providing a site which is free from any health risk posed by an environmental/health hazard. Children in care need to be in the safest place possible. For additional information, please consult the following websites.

Lead information:	www.health.ny.gov/environmental/lead/
Pesticides information:	www.ocfs.state.ny.us/main/childcare/pest/
Radon Information:	www.ocfs.state.ny.us/main/childcare/radon/

What is an Environmental Hazard?

Environmental hazards are conditions that expose persons to dangerous substances, which can cause them increased risk of illness or injury.

Path and Route of Exposure

Harmful substances can affect you even if they are miles from your property. They can and do travel. The way/method a harmful substance moves to a surrounding area is known as the "***path*** of exposure." The "***route*** of exposure" refers to how people come into contact with the substances.

Lead-based Paint

Old peeling or chipping lead-based paint, lead dust and soil with lead in it can cause a risk of serious health problems, especially to small children.

Radon

Radon is a natural gas sometimes found in indoor air. You need to determine if you live in a Zone 1 radon site; when referring to the list be sure to look for your town, village or city in addition to the mailing address. If you do not have internet access, you may also contact the New York State Department of Health at (800) 458-1158. A test will be required if one has not already been done.

Gas Stations

While gas stations are not generally an environmental hazard, they are if they have had a recent oil or gasoline spill.

Other Hazard Sources

Other sources of hazards, such as dry cleaners or nail salons, are listed in the Environmental Hazards Guidance Sheet. Additional resources are available from the OCFS website: http://www.ocfs.state.ny.us/main/childcare/default.asp.

Environmental Hazards Inspection

INSTRUCTIONS


Submit


Maintain On-Site

- *All applicants must complete this form*
- *Applicants must read all attached guidelines before completing this form*
- *Applicants should only sign EITHER section 1 OR section 2*
- *Only ONE potential hazard may be reported on this form*
- *If you have more than one to report, please make additional copies before completing*

Applicant Name:

Site Address:
Street Address:
City, State and Zip:
Town/Village of Site Location:

Tear Here

Section 1: NO Environmental Hazards

To the best of my knowledge, NO potential environmental hazards exist on either the day care site or surrounding areas.

Applicant Signature: _____ Date: _____
(mm / dd / yyyy)

You have completed this form.

Section 2: Environmental Hazard(s) Exist: _____
Type of Environmental Hazard

Hazard Location: _____ Distance from Property: _____

Length of Time Hazard Present: _____ Path/Route of Exposure: _____

A potential environmental hazard exists on either the day care site or surrounding areas.

Applicant Signature: _____ Date: _____
(mm / dd / yyyy)

You are required to provide supporting information on the Environmental Hazard Information Form (on the reverse side). You must submit all relevant information with your application. An OCFS representative will review the information and determine whether more information or additional evaluation is necessary.

Environmental Hazards Inspection (continued)

INSTRUCTIONS

Submit **Maintain On-Site**

- *Do NOT complete this side of the form if you signed the "NO Environmental Hazards" box on the reverse side of this form*
- *Check the box or boxes next to the agency or agencies you contacted*
- *Print or type the name of the person you contacted, their phone number or email address and the date*
- *Complete the Recommendation for an Environmental Assessment section*

Hazard Information

Name the environmental hazard you are reporting: _____

_____

Hazard Type: ☐ Natural ☐ Business: _____
(Specify Business Name)

Agencies Contacted

☐ **Regional Office of the Department of Environmental Conservation (DEC)** Date: _____

Contact Name: _____ Email Address or Phone Number: _____

☐ **Health Department** _____
State County City Other Date

Contact Name: _____ Email Address or Phone Number: _____

☐ **Fire Department** Location: _____ Date: _____

Contact Name: _____ Email Address or Phone Number: _____

☐ **Local Municipal Building (or Codes) Department** Date: _____

Contact Name: _____ Email Address or Phone Number: _____

Recommendation for an Environmental Assessment

Did any of the above agencies recommend that an environmental professional conduct an environmental hazard assessment?

☐ **NO** Reason Given: _____

☐ **YES** Reason Given: _____

Type of assessment recommended: _____

_____

This page was intentionally left blank so that the instructions and the form would be side-by-side.

Inside Floor Plan Guide

INSTRUCTIONS • *Please follow the guidelines below when drawing your diagram on the next page*

Inside Floor Plan

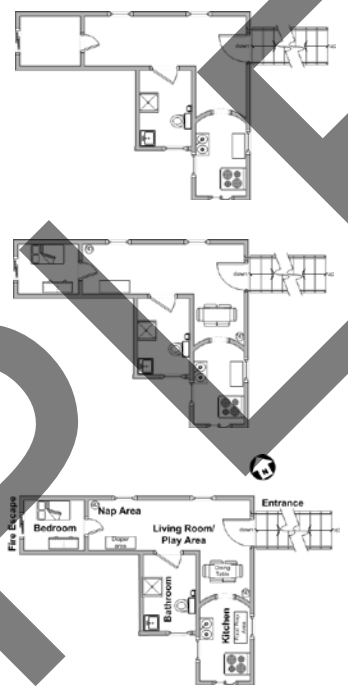
- On the following page, draw an outline of your facility as if you were looking down through the ceiling. If your house has more than one floor, copy the following page and draw a diagram of each floor.

- Show the location of all doors, windows and walls. Label all entrances and exits, including fire escapes. You also need to label all smoke and carbon monoxide detectors.

- Label rooms used for children's nap area, play area and other essential areas. Show bathrooms used by children, sinks used for hand washing, sinks used for food preparation and diaper changing areas.

  NOTE: Sinks used for food preparation may NOT be used for hand washing following diaper changes.

Sample Outline



Sample Drawing

- ☐ Entrance/Exits
- ☐ Stairways
- ☐ Carbon Monoxide Detector (CO)
- ☐ Smoke Detectors (SD)
- ☐ Food Prep Area with Sink
- ☐ Bathroom
- ☐ Diaper Changing Area
- ☐ Nap Area
- ☐ Play Area
- ☐ Doorways
- ☐ Other Essential Areas

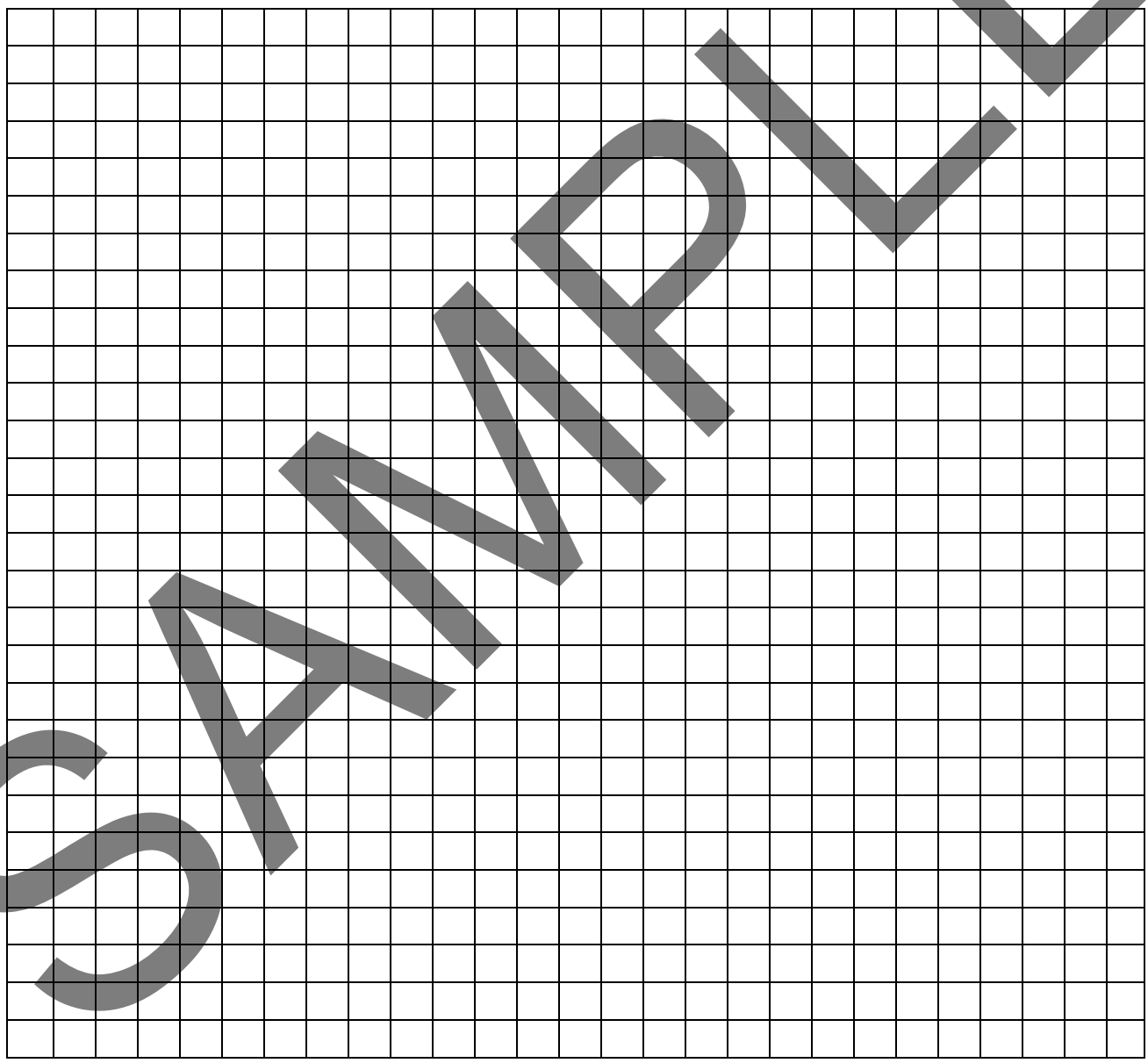
Inside Floor Plan

INSTRUCTIONS

Submit

- *If your home has more than one floor, duplicate this page and complete a page for each floor*
- *The guidelines on the previous page can assist you with your drawing(s)*

Applicant Name:	Floor / Apt #:



Tear Here

Outside Play Area

INSTRUCTIONS

Submit

- *Indicate where the play area is located in relationship to the child care home*
- *Draw a picture of the outside play area that will be used by the children*
- *Include entrance, exits, fencing, play equipment, water hazards, surrounding streets and location in regard to the child care facility*
- *Include on the diagram the route used to get to the play area from your child care facility, noting nearby creeks, ponds, wells and ditches along the route used*

Applicant Name:

Location

Location of play area: ☐ Backyard ☐ Park ☐ Schoolyard ☐ Other _____

Indicate the method used in getting to the play area: _____

This page was intentionally left blank so that the instructions and the form would be side-by-side.

Emergency Plan: Evacuation/Relocation Guide

INSTRUCTIONS

- *The following pages comprise the Emergency Plan, including Evacuation and Shelter in Place*
- *Use the information in this guide to assist you in answering the questions on the Emergency Plan sheet*
- *You must share this information with parents*
- *Depending upon your location, you may want to develop additional plans for special circumstances (weather, power plants, hazardous spills, etc)*
- *Additional information on Radiological (Nuclear) Emergency Planning Zones is included in the appendix*

Regulations

Regulations require that a written plan for the emergency evacuation of children be developed. This plan must be filed in a readily accessible place. The Emergency Plan must place primary emphasis on the immediate evacuation of the children.

Scope

The Emergency Plan form provides the information you need to develop clear and comprehensive procedures for the safe, quick, and orderly evacuation of children and staff.

A written Emergency Plan establishes a consistent procedure, so that everyone knows what to do in an emergency.

Evacuation Drills

At least once per month, during every shift of care, your program is required to conduct an evacuation drill. A written record of these drills must be maintained on site. This record must include total egress time from the time the alarm sounds until everyone reaches the meeting place. The record must also list the number of children in care and adults present at the time, the exit that was used, and any comments.

An evacuation drill is an opportunity to practice and evaluate your evacuation plan and to improve upon prior performance.

Evacuation Methods

Determine the best way to safely evacuate each of the four age groups (infants, toddlers, preschool and school age) as well as children with special needs from the home in case of an emergency. Take into consideration that infants may need to be carried and that toddlers may require individual guidance and more assistance than preschool and school age children. As part of the Emergency Plan, it is important to consider how you will transport children's records, family contact information, and necessary supplies. It is recommended that a portable emergency kit containing these items be kept in a location easily accessible to the exit.

NOTE: Take attendance before and after evacuating the building.

Meeting Place

Determine a place for everyone to meet after evacuating the home. The meeting place should be:

- Out of the path of emergency vehicles
- A safe distance from the building
- Clear of snow, ice, water, and mud

The meeting place should have enough space for all adults and children to assemble. It is preferable to have an area that is shaded and protected from the elements (for example, a nearby building or an area with a roof).

Relocation Site(s)

Primary Relocation Site:

You must arrange for a place to take the children in the event that you are not permitted to return to the home within a reasonable period of time. The site should be within a safe walking distance, and open during the customary days and hours that you provide care. This site should be suitable to shelter the children safely and comfortably for a few hours. Relocation sites should allow you to contact parents by telephone. It is very important to establish an agreement with the owners of your relocation site to temporarily use their building in an emergency. This includes neighbors, nearby businesses, public buildings, schools, or faith-based institutions.

Secondary Relocation Site:

You must also select a secondary site; in certain circumstances, the primary cannot be used. Consider identifying additional locations within walking distance of your home that are suitable to your program needs.

Other Relocation Sites:

In case of emergency situations requiring evacuation from your home and neighborhood follow instructions of local officials.

Emergency Plan: Evacuation/Relocation

INSTRUCTIONS

Submit

Maintain On-Site

- *Use the guide on the previous page to assist you in answering the following questions*
- *This plan should be reviewed with all caregivers and parents before an emergency*
- ***The safe evacuation of children is the FIRST priority. Children must never be left without supervision.***

Applicant Name:

Evacuation Drills

Drills should be conducted in exactly the same manner as an actual emergency (except for notifying emergency personnel). You are required to keep a written record of monthly evacuation drills.

How will you begin the drill? _____

What will you take with you? _____

In an Emergency

How will you notify the children and staff of an emergency (such as an alarm sounding)? _____

Key Points

- Remain calm and account for all the children
- Take the attendance record, parent contact information & emergency supplies with you
- Leave the building
- Close doors
- Take attendance after leaving the building

Method of Evacuation

Describe how all the children, including infants, will be evacuated from the home: _____

During the evacuation, describe how you will ensure that no one is left alone at any time: _____

Exits and Meeting Places

Identify the primary and secondary exits for emergency evacuation and the meeting place for that exit. Separate meeting places for each exit may be necessary in larger buildings.

Primary Exit	Meeting Place

Secondary Exit	Meeting Place

Tear Here

Emergency Plan: Evacuation/Relocation (cont'd)

Applicant Name:

Notifications

These numbers **MUST** be posted on or next to your phone.

Emergency	Poison Control
911	

How will you ensure that the children's parents are notified of an emergency? _____

_____

_____

Relocation Site(s)

If it appears that you will not be able to return to your day care home, identify the relocation site(s) where you will take the children until their parents can pick them up. You must obtain permission from the person in charge of each location. Please enter the address and phone number of the relocation site (if applicable). When developing this plan, consider how you will get there (walk, car, bus, etc.). This information must be shared with the parents.

Primary relocation site: _____
Name

_____ _____ _____
Street Address City Phone No.

Transportation Method: _____

Secondary relocation site: _____
Name

_____ _____ _____
Street Address City Phone No.

Transportation Method: _____

Other relocation site: _____
Name

_____ _____ _____
Street Address City Phone No.

Transportation Method: _____

This page was intentionally left blank so that the instructions and the form would be side-by-side.

Emergency Evacuation Diagram Guide

Inside Floor Plan

1. On the next page, redraw your inside floor plan diagram. Show the location of doors, walls, and windows so that each room or space is bordered with a line.

2. Label all exits (EXIT), fire extinguishers (F), and smoke (SD) and carbon monoxide (CO) detectors; also include stairs and fire escapes (FE) if applicable. Do not label rooms, sinks, or other amenities.

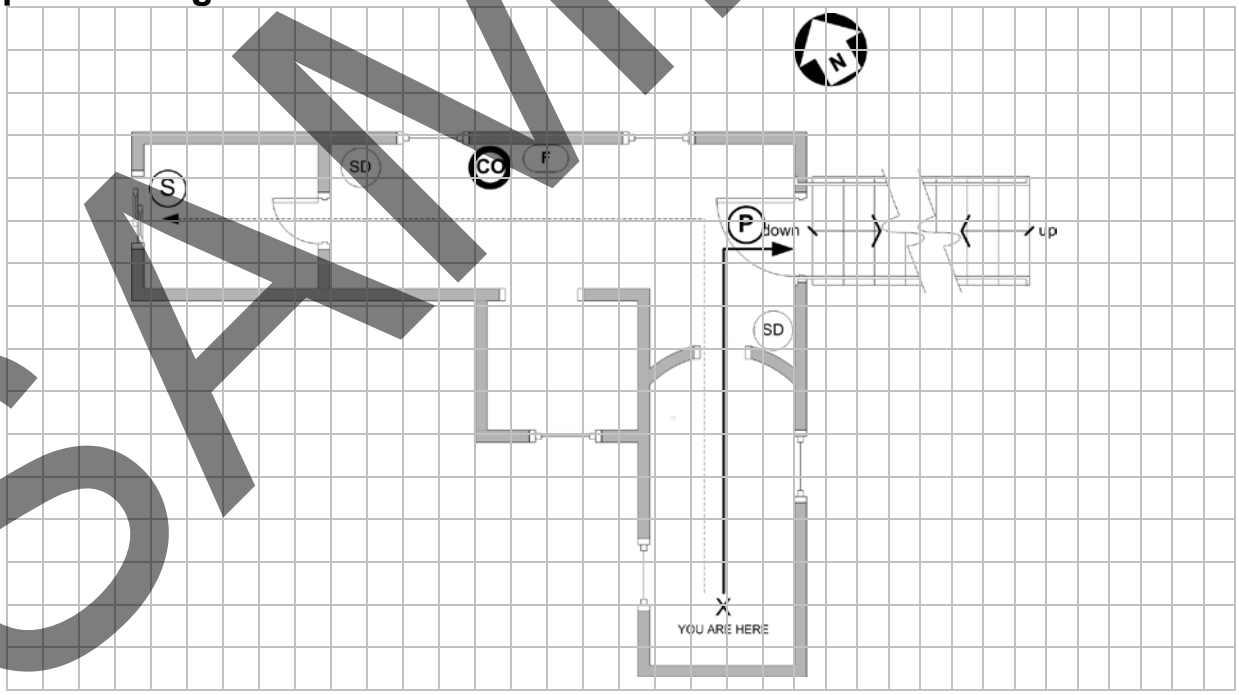
3. Indicate the ***primary*** exit from the residence by drawing a solid arrow, marked with a large "P", leading from the room to the exit. Indicate the ***secondary*** exit by drawing a dotted arrow, marked with a large "S".

4. It is required that a copy of the evacuation diagram be posted in a visible location and recommended that a diagram be posted in each room approved for child care. Include the escape path from that room to the nearest exit.

Items Checklist

	Item	Symbol
☐	Carbon Monoxide Detector	(CO)
☐	Smoke Detector	(SD)
☐	Exit	(EXIT)
☐	Fire Extinguishers	(F)
☐	Primary Exit	P→
☐	Secondary Exit	S- - →
☐	Fire Escapes	(FE)
☐	Stairs	
☐	You Are Here	X

Sample Drawing



Emergency Evacuation Diagram

INSTRUCTIONS

- *Follow the guidelines on the opposing page to draw your diagram*
- *The diagram must be posted in a visible location*
- *Consider posting a diagram in each room approved for child care*

Submit

Maintain On-Site

Applicant Name:	Floor / Apt #:

Tear Here

This page left blank intentionally.

This page was intentionally left blank so that the instructions and the form would be side-by-side.

Emergency Plan: Shelter in Place Guide

INSTRUCTIONS

Maintain On-Site

- *The following pages address the portion of the Emergency Plan that involves sheltering in place*
- *Use the information in this guide to assist you in answering the questions on the Shelter in Place sheet*
- *Depending upon your location, you may want to develop additional plans for special circumstances (weather, power plants, hazardous spills, etc)*

What is Shelter in Place

Shelter in Place is a response to an emergency that creates a situation in which it is safer to remain in the building rather than to evacuate.

Generally, Shelter in Place means simply staying indoors. In some situations, sheltering in place includes additional precautions like locking all doors, closing all window shades, remaining in a room away from large windows or turning off heat and air conditioning systems. Most situations calling for sheltering in place are in response to events that have a relatively short duration of hours, not days or weeks. A Shelter in Place **drill** does not include an overnight stay and typically requires no more than a half an hour to complete.

When to Shelter in Place

Some situations that might require sheltering in place are:

- Severe weather conditions
- Extreme temperatures (cold or hot)
- A public disturbance that escalated to violent acts
- Chemical or biological spill
- Rabid animal sighting

Local authorities will provide you with information during an actual event. It is crucial that you follow their instructions during and after emergencies regarding Shelter in Place.

Where You Can Shelter

Choose room(s) in your house or apartment for your shelter with as few windows and doors as possible. A large room, preferably with a water supply, is desirable – something like a master bedroom that is connected to a bathroom. Different emerencies may require a different response. **You should follow the directions provided by your local emergency services.**

Design Your Plan

- Designate safe location within the home
- Method used to alert children, caregivers and household members of emergency
- Method to ensure everyone is moved to a safe location (using daily attendance sheet, performing room searches and head counts, etc)
- Method to alert emergency responders (who calls 911 and how, if needed)
- Identify how you will ensure everyone arrived safely at safe location (using daily attendance sheet and head counts, etc)
- Method to engage children in quiet, safe activities while providing competent supervision
- Method to inform parents in advance of your drills as well as during an actual emergency

Sheltering Supplies

You must have on site a variety of supplies including food, water, first aid and other safety equipment. In a real emergency, parents may be unable to pick up their children. For this reason, your plan must take into account a child's needs for an overnight stay. You must be ready to provide continuous care for the duration of the emergency. Food supplies must be non-perishable and of sufficient quantity for all children in care.

Required Items

- First aid kit
- Telephone
- Flashlight with extra batteries
- Food & Water
- Infant supplies (if applicable)

Items to Consider

- Toileting/diapering supplies
- Battery-powered radio
- Materials to cover windows & vents, if needed
- Games & books
- Medications (if applicable)

The Office offers emergency preparedness training available on our website.

Practice, Practice, Practice!

It is necessary to perform & document drills twice per year. The drill form is available online.

Parents must be notified in advance of your Shelter in Place drills.

Emergency Plan: Shelter in Place

INSTRUCTIONS

Submit

Maintain On-Site

- *Use the guide on the previous page to assist you in answering the following questions*
- *Practice drills must be conducted at least twice per year*
- *This plan must be posted or filed in a readily accessible place; consider posting next to the evacuation diagram by the exits*
- *This plan should be reviewed with all caretakers before an emergency*
- *Please PRINT clearly*

Applicant Name:

The Location(s)

Identify the room(s) where you will Shelter in Place. Use the space below to indicate the room(s) you've chosen:

Primary Room: _____

Secondary Room: _____
(if space allows)

Room & Supply Preparation

Does the room have windows? _____

What supplies will you keep stocked? _____

_____

_____

Where will you keep your Shelter in Place supplies? _____

_____

_____

How will supplies be accessed in an emergency? _____

_____

_____

How often will you inspect the condition of your emergency supplies?

_____

_____

Tear Here

Emergency Plan: Shelter in Place (continued)

Applicant Name:

Alerting Staff, Children, 911, Parents & OCFS

How will you notify everyone in the home of the need to Shelter in Place? _____

If necessary, who will call 911 and how? _____

How will you notify parents of drills and actual emergencies? _____

In the event of an actual emergency, when will you notify Office of Children & Family Services? _____

Occupying the Children While Sheltering

What types of activities will you provide to occupy the children while sheltering in place?

How will you meet the health, safety and emotional needs of children? _____

Program Information

Available Resources

Valuable information is available from your local child care council and other resources. This information will help you create an appropriate environment, provide guidance and use best practices to engage children. It will also help resolve conflict and handle issues such as child biting and tantrums. For additional resources, please consult the OCFS website.

Developing Your Plan

ACCEPTABLE METHODS

1. Redirect. In a conflict, give an alternate toy or task to one of the children competing for the toy.
2. Focus on "Do" rather than "Don't." For example, "We walk inside" instead of "Stop running inside."
3. Offer choices: "You can either sit on the rug or at the table for story time."
4. Encourage children to use friendly words rather than physical acts. For example, suggest using the phrase, "I was playing with that toy first."
5. Praise positive behavior: "Thank you for using your words!"
6. Model desired behaviors; children learn by example: Use "Please" and "Thank you."
7. Arrange the program space to positively impact children's behavior. For example, create defined areas (such as reading space or dress up area).
8. Apply all rules consistently, appropriate to the age and developmental level of the children. For example, all children must wash their hands before eating. Some may require help washing their hands while others should be able to do this independently.
9. Listen to the children and respond to their needs before trouble starts; work with the children to achieve their goals. Keeping the children engaged with activities helps prevent conflict.
10. For preschool and school age children, it may be appropriate to involve the children in the development of the rules and consequences.
11. Physical ***intervention*** as defined in regulation is permitted.

PROHIBITED

1. Corporal punishment is prohibited. Corporal punishment is punishment inflicted directly on the body including, but not limited to, the following:
   a. Shaking, slapping, twisting or squeezing
   b. Demanding excessive physical exercise, excessive rest or strenuous or bizarre postures
   c. Compelling a child to eat or have in his/her mouth soap, food, spices or foreign substances.
2. The use of room isolation is prohibited. No child can be isolated in an adjacent room, hallway, closet, darkened area, play area or any other area where a child cannot be seen or supervised.
3. Food cannot be used or withheld as a punishment or reward.
4. Toilet training methods that frighten, demean or humiliate a child are prohibited.
5. Any abuse or maltreatment of a child, either as an incident of discipline or otherwise, is absolutely prohibited. Any child care program must not tolerate or in any manner condone an act of abuse or neglect of a child by an employee, volunteer, any person under the provider's control or an individual residing in the home.
6. Physical ***restraint*** as defined in regulation is prohibited.

Behavior Management for Child Care

INSTRUCTIONS

Submit

Maintain On-Site

- *Providers are required to have a written plan to share with parents and staff. Make copies available*
- *Consider the age and developmental level of the children in developing your plan*
- *Only approved staff may discipline children*
- *Please PRINT clearly*

Applicant Name:

1. How will you encourage children to get along with others?

2. How will you respond to difficult behaviors? Provide examples of some difficult behaviors and how you would respond.

3. How will you help children solve their own problems? Provide an example, including a description of how you will ensure those solutions are carried out.

4. How is your home set up to encourage acceptable behavior?

5. How will you vary your techniques so that they are effective with children of different age groups?

Tear Here

This page left blank intentionally.

Developing Your Program

INSTRUCTIONS

Submit

Maintain On-Site

- *Group Family Day Care Providers must develop a program of daily routines for the children in their care*
- *Complete each section applicable to the age group(s) for which you will provide care. If you will not provide care for a particular age group, leave that section blank*
- *You will need to notify your licensor/registrar of any changes to the age groups for which you provide care and provide new program documentation*
- *All caregivers and parents must be informed of these routines*

Applicant Name:

Developmental Areas

Your daily routine should include activities which foster development in the following areas:

- Cognitive
- Educational
- Emotional
- Safety / Health
- Social Skills / Interaction
- Language
- Recreational
- Physical Development
- Cultural Awareness

Age Appropriate Routines

Infants

How will you meet the needs of the infants while providing supervision for the other age groups?

How will your schedule change should an infant have a difficult day?

How will diaper changes and feedings fit into the programming and supervision of the other age groups?

How will you keep the area safe and childproof for infants, while still meeting the needs of the other age groups?

Describe the area where infants will be located most of the time.

Describe how your program space and daily routine will promote physical development.

(Continued on reverse side)

Tear Here

Developing Your Program (continued)

Applicant Name:

Toddlers

Describe some activities that you will use to encourage toddler development and independence.

Describe how you will encourage toilet training while adequately supervising the children.

Describe how you will modify activities so that toddlers are able to participate with older children.

Preschoolers

Describe some activities that you will use to encourage preschooler development and independence.

Describe how you will encourage independent toileting while adequately supervising all of the children.

Describe activities to occupy preschool children while attending to the needs of the other children in your care.

School-age

Describe educational, social and recreational activities that you will provide to engage the school-age children.

Describe areas and equipment designated solely for the use of the school-age children.

Describe the supervision policy that you will use for school-age children (attach a sample parental permission slip).

Program Daily Schedule: Putting it All Together

INSTRUCTIONS


Submit


Maintain On-Site

- *Use the information on the Developing Your Program pages for this schedule*
- *Infant schedules should be obtained in writing from their parents*
- *If you have multiple shifts of care, copy and complete this form for each shift*
- *This form should list generic activities such as: Meals, Snacks, Rest Period, Outdoor Play, Indoor Play, Reading Time, Quiet Time and Physical Activity*
- *Be flexible enough with the schedule to accommodate the needs of all children*
- *Be sure to include a variety of active and quiet play*
- *Please PRINT clearly*

Applicant Name:

Daily Schedule	Activities		
	Toddler	Preschool	School-Age
Start Time **AM** **____:____ PM**			
Mid Time **AM** **____:____ PM**			
End Time **AM** **____:____ PM**			

Tear Here

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Program Hours of Operation

INSTRUCTIONS

Submit

- *Indicate the days and hours you plan to operate your program*
- *If you plan on providing overnight or evening care contact your licensor or registrar for additional requirements*
- *Please PRINT clearly*

Applicant Name:

Hours of Operation

Traditional child care operating days and hours are Monday through Friday, approximately 6:00 A.M. to 7:00 P.M.

Below are two (2) examples of how this form might be completed. Your hours may differ.

Day	Shift 1	Shift 2	Shift 3
Monday	Start: 8:00 AM/PM End: 6:00 AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM

Day	Shift 1	Shift 2	Shift 3
Monday	Start: 5:00 AM/PM End: 9:00 AM/PM	Start: 3:00 AM/PM End: 7:00 AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM

Your Planned Hours of Operation

Complete times for the days you plan on caring for children. Any changes to these hours require written approval.

Day	Shift 1	Shift 2	Shift 3
Sunday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Monday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Tuesday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Wednesday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Thursday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Friday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM
Saturday	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM	Start: ___:___ AM/PM End: ___:___ AM/PM

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Health Care Plan Guidelines

INSTRUCTIONS


Submit


Maintain On-Site

- *Group Family Day Care providers must develop, submit, and maintain on-site a copy of the Health Care Plan*
- *This side of the form is to help you select the health category of children for which you will care*
- *Health Care Plan forms specific to the category of children to be served will need to be completed as part of the required Health Care Plan*
- *Health Care Plan forms will be provided based on the selections indicated on this form*

Applicant Name:

HEALTH CATEGORY DEFINITIONS

A group family day care provider must establish practices that will limit the spread of germs and illness. The Health Care Plan is the way these practices are communicated to all caregivers and to parents. You are allowed to decide whether you will care only for children who are well, or for children who have any mild or moderate illness. Children who are contagious should not remain in your care; you, your own family and the other children in your care might be at risk of coming down with the same illness. However, children who have a mild illness can remain in your care provided you take some simple precautions.

NOTE: The definitions below do not include children who are protected under the Americans with Disabilities Act (ADA). Programs must consider each child's case individually and comply with the requirements of the ADA.

WELL CHILDREN: Children who do not show any symptoms of mild or moderate illness as defined below.

MILDLY ILL CHILDREN: A child who meets any of the following criteria is defined as "mildly ill":

- The child has symptoms of a minor childhood illness which does not represent a significant risk of serious infection to other children.
- The child does not feel well enough to participate comfortably in the usual activities of the program but is able to participate with minor modifications, such as more rest time.
- The care of the child does not interfere with the care or supervision of the other children.

MODERATELY ILL CHILDREN: A child who meets any of the following criteria is defined as "moderately ill":

- The child's health status requires a level of care and attention that cannot be accommodated in a child day care setting without the specialized services of a health professional.
- The care of the child interferes with the care of the other children and the child must be removed from the normal routine of the child care program and put in a separate designated area in the program, but has been evaluated and approved for inclusion by a health care provider to participate in the program.

SPECIAL HEALTH CARE NEEDS:

- A child with special health care needs is defined as: "a child who has a chronic physical, developmental, behavioral or emotional condition expected to last 12 months or more and who requires health and related services of a type or amount beyond that required by children generally."
- Any child identified as a child with special health care needs will have an individual plan which will provide all information needed to safely care for the child. This plan will be developed with the child's parent and health care provider.

YOUR SELECTIONS

Indicate the categories of children you will accept in your group family day care home:

☐ Well Children
☐ Mildly Ill Children
☐ Moderately Ill Children
☐ Children with Special Health Care Needs

PLEASE COMPLETE BOTH SIDES OF THIS FORM

(Continued on reverse side)

Tear Here

Health Care Plan Guidelines (continued)

INSTRUCTIONS

Submit

Maintain On-Site

- *Group Family Day Care Providers must develop, submit, and maintain on-site a health care plan*
- *This side of the form is to help you select the medications, if any, that you intend your program to administer*
- *Health Care Plan forms will be provided based on the selections indicated on this form*

Applicant Name:

OPTIONS FOR ADMINISTERING MEDICATIONS

TOPICAL OVER-THE-COUNTER PRODUCTS: A program may choose to administer over-the-counter topical ointments, lotions and creams, and sprays. This includes sunscreen products and topically applied insect repellant. While written parental permission is required, Medical Administration Training (MAT) is NOT required to apply these products.

MEDICATIONS: A program may choose to administer prescription and non-prescription medication including pain relievers, cough syrups and oral analgesics. This includes medications given by the following routes: oral, topical, eye, ear, and inhaled medications, medicated patches and epinephrine via an auto-injector device. In order to be approved to administer medication, other than over-the counter topical ointments, sunscreen and topically applied insect repellant, providers must have a valid:

- MAT certificate **OR** exemption from the training requirements as per regulation
- CPR certificate which covers all ages of children the program is approved to care for as listed on the program's license or registration,
- First aid certificate which covers all ages of children the program is approved to care for as listed on the program's license or registration.

Initial and ongoing consultation with a Health Care Consultant is required as part of the decision to administer medications. Additional information is provided in the plan itself.

EMERGENCY MEDICATIONS: For non-MAT certified individuals, there are only two conditions under which your program is allowed to administer emergency medications: severe allergic reactions (anaphylactic shock) and asthma. An approved caregiver may administer an epinephrine auto injector, Diphenhydramine in combination with an auto injector, and /or asthma inhaler and nebulizers.

YOUR SELECTIONS

Please indicate which categories of medications you will administer to the children in your care. Check all boxes that apply.

☐ Topical Over-the-counter Products
☐ Medications: *this will require Medication Administration Training (MAT) and approval by the Office*
☐ Administer Emergency Medications: *additional requirements apply*
☐ None

Agreements

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Child Support Obligation Statement

INSTRUCTIONS

Submit

- *If you are four or more months behind in your child support obligations, General Obligations Law requires that we issue you a license for no longer than a period of six months*
- *For more information, see **Appendix** for **Child Support Obligation Statement***
- *Please PRINT clearly*

Applicant Name:

Statements

As of the date of this application, do you have an obligation to pay child support?

☐ **No,** I do not.

☐ **Yes,** I am under an obligation to pay child support.

If you answered "Yes", please check any of the following conditions that apply to you.

☐ I am not four months or more in arrears in the payment of child support.

☐ I am making payments by income execution, by court agreed payment or repayment plan, or by a plan agreed to by the parties to the support proceeding.

☐ My child support obligation is the subject of a pending court proceeding.

☐ I am currently in receipt of public assistance or supplemental security income (SSI).

☐ None of the above apply.

Notarized Signed Certification

ALL APPLICANTS MUST SIGN THIS FORM IN THE PRESENCE OF A NOTARY PUBLIC

I hereby solemnly swear that the information provided by me in this certification is true and accurate to the best of my knowledge. I acknowledge that this statement is given under oath.

Owner Signature: _____ Print Name: _____
Sign in the presence of a notary

Sworn to before me this _____
Day

day of _____ _____
Month Year

_____
Notary Public – State of New York (affix stamp)

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Applicant Compliance Agreement

INSTRUCTIONS

Submit

- *This form is an attestation that all information in the application is true and accurate and should not be signed or submitted until the rest of the application has been completed*
- *Before signing the statement below, read and familiarize yourself with Parts 416 & 413 of the regulations*
- *For more information, see **Appendix** for **Labor & Tax Responsibilities***
- *Please PRINT clearly*

Applicant Name:

Program Qualifications Statements

- I certify that I am 18 years of age or older.
- I have read and understand Parts 416 & 413 of the New York State Office of Children and Family Services regulations for the operation of a Group Family Day Care Home. I will operate the facility in compliance with these regulations.
- I understand that I must report to the State Central Register (1-800-635-1522) any incidents of suspected child abuse or maltreatment concerning any child in my care.

Labor & Tax Statements

☐ I am not an employer,

-or-

☐ I am an employer and I certify that to the best of my knowledge and belief, I am operating my program in compliance with federal and state labor and tax laws.

I am providing those employment benefits (minimum wage, social security, federal and state unemployment insurance, workers' compensation, and disability benefits) for which I am responsible. ☐ **Yes** ☐ **No**

Statement of Accuracy and Authenticity

To the best of my knowledge the statements in this application are true and accurate. I understand that my failure to truthfully and accurately record any information may constitute grounds for denial, suspension, limitation or revocation of the license/registration to provide child care at this site.

The submission of forged or altered application documents may be a felony or misdemeanor. In addition to being subject to criminal prosecution, anyone found to have submitted such documents may be subject to fines by the NYS Office of Children and Family Services, and/or denial of this application to provide child day care.

I attest that I have not forged or altered any documents submitted as part of this application, and have not submitted documents forged or altered by another.

I attest that I will not hold more than one family day care registration or group family day care license simultaneously.

Applicant Signature: _____ Date: ____/____/____
(mm / dd / yyyy)

Check here (✓) ☐ if any of the forms in this application package were completed by someone other than the applicant.

The following people completed one or more pages in this application: _____

_____

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Appendix

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SCR Processing Fee

Why is There a Fee?

Effective 4/1/11, there is a cost of $25 for SCR clearances. Please read the following for specific requirements as they apply to your program.

A 2011 amendment to Section 424-a(1)(f) of the Social Services Law set forth requirements for fees for conducting database checks through the Statewide Central Register of Child Abuse and Maltreatment (SCR). Prospective day care providers and applicants for employment in day care programs must pay a $25 fee for any database checks conducted through the SCR.

Who Must Pay the Fee?

Anyone with a care-giving role, including household members, must pay the fee. However, the fee paid by the Provider also covers all household members age 18 and over that do not have a care-giving role. The following is a list of the roles for which a fee is required:

- Provider (and all household members)
- Assistant
- Substitute
- Employee

The fee requirements do NOT apply to the following roles:

- Volunteers
- Providers of goods and services to day care programs,
- Consultants to day care programs, including Health Consultants and Medication Administrants
- Current employees who have previously been screened through the SCR if the program elects to re-screen current employees.

Acceptable Payment Methods

There are four methods of acceptable payment of the fee. These are:

1. Certified check;
2. Postal or bank money order;
3. Teller's check; or
4. Cashier's check

The check or money order above must be payable to: "NYS OFFICE OF CHILDREN AND FAMILY SERVICES."

The payment must include the name(s) of the applicant(s) so that it may be properly processed.

The application will not be processed without the required payment of the fee.

Nuclear Emergency Planning Zones

There are three (3) nuclear power plant sites in New York State. Some child care programs may be located within the 10 mile Emergency Planning Zone surrounding these nuclear facilities. It is recommended that you contact your local police, fire or emergency planning office for more details on preparations and notifications. The nuclear power facilities and the counties they impact are listed below, along with contact information for each county.

Nuclear Facility	County & Contact Information
Indian Point Energy Center (located in Buchanan, NY)	**Orange County Department of Emergency Services** 22 Wells Farm Road Goshen, NY 10924 (845) 615-0479
	Putnam County Office of Emergency Services 112 Old Route Six Carmel, NY 10512 (845) 808-4000
	Rockland County Office of Fire & Emergency Services 35 Fireman's Memorial Drive Pomona, NY 10907 (845) 364-8900
	Westchester County Office of Emergency Management Department of Emergency Services HVTMC – 200 Bradhurst Ave Hawthorne, NY 10532 (914) 864-5450
Nine Mile Point Nuclear Station/ **James A. Fitzpatrick** (located in Scriba, NY)	**Oswego County Office Of Emergency Management** 200 North Second Street Fulton, NY 13069 (315) 591-9150
R.E. Ginna Nuclear Power Plant (located in Ontario, NY)	**Monroe County Emergency Management Office** 1190 Scottsville Road, Suite 200 Rochester, NY 14624 (585) 753-3803
	Wayne County Emergency Management Office 7336 Route 31 Lyons, NY 14489 (315) 946-5663

For assistance in determining whether your program is located within a 10 mile radius of any of the above nuclear power stations, each nuclear facility provides information on their emergency planning zones on their websites. For more information, please visit www.ocfs.ny.gov.

Labor and Tax Responsibilities

Disability Benefits

Disability Benefits are temporary cash benefits payable to an eligible wage earner who is disabled by an injury or illness that is not related to the person's employment. Supplementing the workers' compensation system, the Disability Benefits Law ensures protection for wage earners by providing for weekly cash benefits to replace, in part, wages lost because of injuries or illnesses that do not occur in the course of employment. Disability Benefits insurance is paid for either jointly by the employer and employee or entirely by the employer. Employers may voluntarily provide Disability Benefits for their employees when they are not required to do so.

Disability Benefits insurance may be purchased from any insurance company authorized to write such Benefits insurance in New York State, or from the State Insurance Fund, a State agency headquartered at 199 Church Street, New York, N.Y. 10007. For help determining whether you are required to provide Disability Benefits insurance or more information about Disability Benefits rates, forms and procedures, contact the nearest district office of the Workers' Compensation Board at the number listed in your telephone directory.

Workers' Compensation

Workers' compensation is insurance, paid for by the employer. This insurance provides cash benefits and medical care for workers who become disabled because of an injury or sickness related to their job. If death results, benefits are payable to the surviving spouse and dependents. Workers' compensation insurance may be purchased from any private company licensed to write such coverage in New York State or from the State Insurance Fund, a State agency headquartered at 199 Church Street, New York, N.Y. 10007. For more information about Workers' compensation rates, forms and procedures, contact the nearest district office of the Workers' Compensation Board at the number listed in your telephone directory.

Minimum Wage Requirement

Under the Federal Labor Standards Act, employees must be paid no less than the federal minimum wage unless they are classified as exempt. When this is the case, the minimum wage requirements may be different in New York State. Both federal and state minimum wage and exemption levels are subject to change. For assistance, contact the nearest Wage and Hour Division of the United States Department of Labor at the number listed in your telephone directory.

Unemployment Taxes

The state and federal unemployment tax systems pay unemployment compensation to workers who have lost their jobs. Most employers pay both a state and federal unemployment tax. However, even if you are exempt from the state tax, you must still pay the federal unemployment tax (FUTA). You must pay FUTA as the employer. It cannot be collected or deducted from your employee's wages. For help determining whether you are required to pay the FUTA tax or more information on the FUTA rate, forms, filing procedures or general assistance, you may contact the nearest offices of the Internal Revenue Service (IRS) at the number listed in your telephone directory. For help in determining whether you are required to pay New York State Unemployment Insurance, for more information on the filing procedures, or for general assistance, contact the nearest office of the Liability and Determination Section of the NYS Department of Labor, Division of Unemployment Insurance. The number is listed in your telephone directory.

Social Security Taxes (FICA)

The Federal Insurance Contributions Act (FICA) provides for a federal system of old age, survivors, disability, and hospital insurance. This system is financed through social security taxes, also known as FICA taxes. The FICA requirement applies whenever you pay someone with whom you have an employer / employee relationship. As an employer, you must withhold FICA from your employees' earnings and must pay an equal amount from your own funds based on a percentage rate of the employee's current salary. For help determining whether the FICA requirement applies to you or for more information and general assistance, you may contact the nearest office of the Internal Revenue Service (IRS) at the number listed in your telephone directory.

Other Legal Considerations

Child Support Obligation (Section 3-503 General Obligation Law)

The requirements of the General Obligations Law may affect your license/registration to provide child care if you have an obligation to pay child support and you are not doing so. Persons who are four months or more behind in their child support payments may be subject to suspension of their business, professional and/or driver's licenses. The license/registration for which you are applying is considered a business license.

This means that if you are four or more months behind in your child support obligations at the time of your application to provide child care, General Obligations Law requires that we issue you a license/registration for no longer than a period of six months. We can only extend that period beyond six months if you submit certification that you have come into compliance with the terms of your obligation. We will be happy to send you the necessary form for this purpose should you require it. Please note that any false statement on that certification would be a Class E Felony under Section 175.35 of the Penal Law.

If, during the term of your license/registration, you are found by a court to be four or more months behind in your child support payments, the court could order the New York State Office of Children and Family Services or the New York City Department of Health to take action to suspend your license/registration. You may not care for children with a suspended license/registration.

Social Security & Tax Identification Numbers

The purposes for which state and local governments may collect social security numbers are established by Federal Law Title 42, The Public Health and Welfare Chapter 7, Social Security Act [42 USCS §405 (2005)]. This statute allows state and local governments to collect social security number for official state business. Section 5 of the State Tax Law requires every state agency, as part of the procedure for granting, renewing, amending, supplementing or restating the license or registration of any person, partnership, corporation or other organization, to obtain an applicant's social security number or, if applicable, a federal employer identification number. This information is collected as part of the administration of the taxation system and is one of the permissible reasons for collection of social security numbers established by federal law.

A federal identification number is also referred to as a federal tax identification number and/or an employer's identification number (EIN). A federal tax identification number is issued for tax purposes much like a social security number is given to an individual. As such, a sole proprietor, legal partnership or other business entity that is applying for a license or registration may submit a federal tax identification number or EIN in place of a social security number.

Both social security number and federal identification number are confidential and are only accessible by parties for whom it is necessary in order to conduct official state business.

Local Zoning Ordinances

Under Section 390(12) of the Social Services Law (SSL), local municipalities can exercise jurisdiction over the family or group family day care home in regard to sanitation, health, building construction, and fire code issues. However, local municipalities cannot impose requirements upon family or group family day care homes that are not applicable to all residential dwellings in the same class as the dwelling in which the family or group family day care home is located.

This means local municipalities are prohibited from imposing any requirements on family-based providers that are not also required of all residents. Local zoning laws and other local ordinances cannot impede, restrict, or prohibit the operation of family or group family day care homes in one or two-family dwellings or in multiple dwellings. Special rules cannot be created and enforced upon family or group family day care homes.

If you believe your town, city, or county is imposing additional requirements on your home based on the fact that you are operating a child care program, please contact your licensor or registrar for more information.

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If you believe your town, city, or county is imposing additional requirements on your home based on the fact that you are operating a child care program, please contact your licensor or registrar for more information.

List of Regional Offices

ALBANY REGIONAL OFFICE
NYS Office of Children and Family Services
Albany Regional Office
52 Washington St. Rm 309S
Rensselaer, NY 12144
(518) 402-3038
Serving the counties of: Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington

BUFFALO REGIONAL OFFICE
NYS Office of Children and Family Services
Buffalo Regional Office
Room 545, 5th Floor
Ellicott Square Building
295 Main Street
Buffalo, NY 14203
(716) 847-3828
Serving the counties of: Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming

LONG ISLAND REGIONAL OFFICE
NYS Office of Children and Family Services
Long Island Regional Office
Perry Duryea State Office Building
250 Veterans Memorial Hwy, Suite 2a-2o
Hauppauge, NY 11788
631-240-2560
Serving the counties of: Nassau and Suffolk

ROCHESTER REGIONAL OFFICE
NYS Office of Children and Family Services
Rochester Regional Office
259 Monroe Avenue, 3rd Fl. Monroe Square
Rochester, NY 14607
(585) 238-8531
Serving the counties of: Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

SPRING VALLEY REGIONAL OFFICE
NYS Office of Children and Family Services
Spring Valley Regional Office
11 Perlman Drive, Pascack Plaza
Spring Valley, NY 10977
(845) 708-2400
Serving the counties of: Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster, Westchester

SYRACUSE REGIONAL OFFICE
NYS Office of Children and Family Services
Syracuse Regional Office
The Atrium Building
100 S. Salina Street, Suite 350
Syracuse, NY 13202
(315) 423-1202
Serving the counties of: Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St. Lawrence, Tioga, Tompkins

FOR CHILD CARE PROGRAMS IN THE 5 BOROUGHS OF NYC

NEW YORK CITY REGIONAL OFFICE
NYS Office of Children and Family Services
New York City Regional Office
80 Maiden Lane, 23rd Floor
New York, NY 10038
(212) 383-1415

DIVISION OF CHILD CARE SERVICES HOME OFFICE

NYS Office of Children and Family Services
Division of Child Care Services
52 Washington St. Rm 309S
Rensselaer, NY 12144
(518) 474-9454