

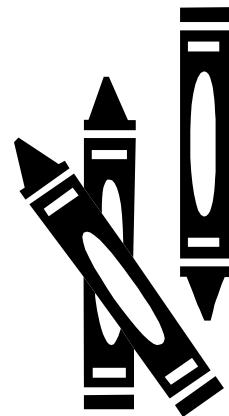
New York State

Office of Children and Family Services

Division of
Child Care Services

New York State Group Family Day Care

SAMPLE



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.

SAMPLE



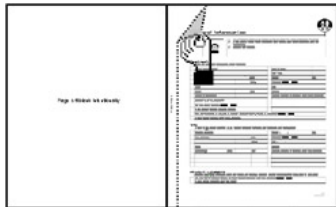
Printed on Recycled Paper

Thank you for inquiring about starting a Group Family Day Care program. We are pleased to send you an application package. Please note that this application booklet expires on . After that date, you must contact the individual noted below to request an updated application booklet.



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

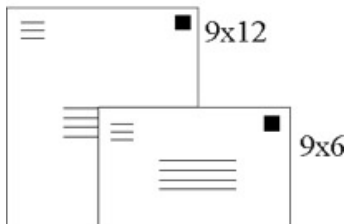
This package contains the information you will need to begin the application process. The checklist, "Group Family Day Care Required Documents", specifies each item which needs to be completed and submitted to begin your application with us. You can use this checklist to make sure you've completed the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

Mailing in the Application

It is not necessary to return this entire booklet to us. Some of the information will be useful to you as you start your child care business. The pages you should mail to us are perforated for easy removal and indicate in their instructions to submit them. It is *required* that you keep copies of certain documents on site, but, 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.

Envelope Sizes



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/417_FDC_regs.asp
Division of Child Care Services Policies:	www.ocfs.state.ny.us/main/becs/policy/
Social Service Law 390:	www.ocfs.state.ny.us/main/childcare/390%20Social%20Services%20Law.doc

Various Household Hazards

Lead information:	www.health.state.ny.us/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
Educational Incentive Program:	www.tsg.suny.edu/eip.shtm
Medication Administration Training:	www.tsg.suny.edu/obtain_renew.shtm
Health and Safety Training:	www.tsg.suny.edu/about_health_safety.shtm

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/childcare/Child_care_forms.asp
Quality Stars New York:	Earlychildhood.org/qsny/
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:

SAMPLE

<i>Identifying Information</i>	A-1	
<i>Requirements</i>	B-1	
<i>Site Information</i>	C-1	
<i>Program Information</i>	D-1	
<i>Agreements</i>	E-1	
<i>Appendix</i>	App-1	

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.

		 Maintain On-Site	 Submit	Date Submitted
	Identifying Information			
	General Information		✓	/ /
	Business Information		✓	/ /
	Requirements			
	First Aid & CPR Certification	✓	✓	/ /
	Fingerprint Request Form			/ /
	Applicant			
	Qualifications		✓	/ /
	References		✓	/ /
	SCR Form		✓	/ /
	Medical Statement	✓	✓	/ /
	Criminal Conviction Statement		✓	/ /
	Assistant			
	Information		✓	/ /
	Qualifications		✓	/ /
	References		✓	/ /
	SCR Form		✓	/ /
	Medical Statement	✓	✓	/ /
	Criminal Conviction Statement		✓	/ /
	Substitute			
	Information	✓	✓	/ /
	SCR Form		✓	/ /
	Criminal Conviction Statement		✓	/ /
	Household Member(s)			
	Medical Statement	✓	✓	/ /
	Criminal Conviction Statement		✓	/ /

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
 Site Information	C-1			
Bodies of Water Attestation	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	✓	✓	/ /
 Program Information	D-1			
Behavior Management	D-3	✓	✓	/ /
Developing Your Program	D-5 thru D-6	✓	✓	/ /
Health Care Plan	D-9 and D-10	✓	✓	/ /
 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			✓	/ /

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SAMPLE



Identifying Information

General Information A-3
Business Information..... A-5

SAMPLE



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SAMPLE



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 licenser.

Applicant

Complete/verify the following information about yourself.

Mr. Mrs. Ms.

Date of Birth: / /

Name:

(mm/dd/yyyy)

Last

First

MI

Mailing Address:

Phone: ()

Ext.

Apt.

Unlisted: Yes No

Floor

City:

Fax: ()

State

Zip

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:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

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Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

Name:

Last

First

MI

Date of Birth: / /

(mm / dd / yyyy)

(Continued on reverse side)

Tear Here



General Information (continued)

INSTRUCTIONS • Please PRINT clearly



Submit

Applicant Name: _____

Site

Print the following information about your program.

On-site Provider: _____ Phone: () _____ Ext. _____
Last First MI

Site Address: _____ Unlisted: Yes No
Apt. _____

City: _____ Floor _____ E-Mail: _____
State Zip

County/Borough: _____ Mailing Address (if different from site address): _____

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

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.



Business Information

INSTRUCTIONS



Submit

- If you have a DBA (Doing Business As), submit your DBA certificate with the application
- Indicate your days and hours of operation
- Complete Legal information section (Check ONE box only)
- 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.

When do you plan on operating? (Complete times for the days you plan on caring for children)

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
AM - ___ PM	AM - ___ PM	AM - ___ PM	AM - ___ PM	AM - ___ PM	AM - ___ PM	AM - ___ PM

Legal Information (Select ONLY ONE checkbox)

- Sole Proprietor** (most common) *This is the legal entity if only one person will be solely responsible for the day care program. Unless a Doing Business As (DBA) form is submitted, the name of the day care program will be the Last Name, First Name of the sole proprietor. The program can only be designated as something other than the name of the sole proprietor if a DBA certificate has been obtained from the county clerk or designated authority.*

DBA form attached

Program Name: _____

SSN: [][]-[][]-[][][][][][] OR Federal ID: [][]-[][][][][][][][][]

- Corporation** *To incorporate, Incorporation papers must be filed with NYS Department of State. A filing receipt and a Certificate of Incorporation must be attached. This entire section must be completed. Unless a DBA certificate is submitted specifying a special name for this day care program, the name of the program printed on the registration/license will be the corporate name.*

Corporate Name: _____

DBA: _____

Federal ID: [][]-[][][][][][][][]

DBA form attached

Mailing Address: _____

Fax: () _____

Apt. _____

E-Mail: _____

Floor _____

City: _____

Contact Name: _____

County/Borough: _____ State _____ Zip _____

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)

Legal Partnership *This is the legal entity type if you and one or more other individuals have formed a legal partnership. If no Doing Business As (DBA) form is submitted, the name of the day care program will be the Last Name, First Name. The program can only be designated as something other than the name if a DBA certificate has been obtained from the county clerk.*

Legal Name: _____	DBA: _____
Mailing Address: _____	Fax: () _____
Apt. _____	E-Mail: _____
Floor _____	Contact Name: _____
City: _____	Contact Phone: () _____
State Zip _____	
County/Borough: _____	

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) *To form an LLC, legal papers must be filed. Unless a DBA certificate is submitted specifying a special name for this day care program, the name of the program printed on the registration/license will be the LLC name.*

LLC Name: _____ DBA: _____

Federal ID: -

Mailing Address: _____ Apt. _____ Fax: () _____

_____ Floor _____ E-Mail: _____

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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SAMPLE



Business Information (continued)

Legal Information (continued)

Unincorporated Association *This is an entity recognized by the IRS, but it does not require legal papers to define it. The registration/license document will list the name of each member of the Association in the 'Issued To' area. If no Doing Business As (DBA) form is submitted, the name of the day care program will be the Last Name, First Name of each member. The program can only be designated as something other than the name if a DBA certificate has been obtained from the county clerk.*

Legal Name: _____ DBA: _____

Federal ID: -

Mailing Address: _____ Apt. _____ Fax: () _____

_____ Floor _____ E-Mail: _____

City: _____ Floor _____ Contact Name: _____

_____ State Zip _____ Contact Phone: () _____

County/Borough: _____

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: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR	Federal ID: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Name: _____		Title: _____	
Last _____ First _____ MI _____			
Address: _____		Phone: () _____	
Street _____ City _____ State/Zip _____			
SSN: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR	Federal ID: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Name: _____		Title: _____	
Last _____ First _____ MI _____			
Address: _____		Phone: () _____	
Street _____ City _____ State/Zip _____			
SSN: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	OR	Federal ID: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	



Requirements

First Aid & CPR Certification Form.....B-3

Fingerprint Request FormB-7

Applicant

Qualifications B-9

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SCR Instructions..... B-14

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Substitute

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SCR Instructions..... B-46

SCR Form..... B-47

Criminal Conviction Statement B-53

Household Member(s)

Medical Statement..... B-55

Criminal Conviction Statement B-57

SAMPLE



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SAMPLE



CPR & First Aid Requirement



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 person on site at all times with a current, OCFS-approved certification in CPR and First Aid.
- The certifications do not have to be held by the same person; one person could be certified in First Aid and another in CPR, but both certifications requirements must be met.
- Care cannot be provided unless the person(s) with these certifications is on site.
- Online certifications 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)
	<input type="checkbox"/> CPR	
	<input type="checkbox"/> First Aid	
	<input type="checkbox"/> CPR	
	<input type="checkbox"/> First Aid	
	<input type="checkbox"/> CPR	
	<input type="checkbox"/> First Aid	
	<input type="checkbox"/> CPR	
	<input type="checkbox"/> First Aid	
	<input type="checkbox"/> CPR	
	<input type="checkbox"/> First Aid	

Provider Signature: _____

Date: ____/____/____
(mm / dd / yyyy)

Tear Here

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SAMPLE

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

SAMPLE



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, On-Site Provider, Site Supervisor, Household Members over the age of 18, Assistants, Alternate Providers, Alternate 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: www.L1enrollment.com.
 - 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://www.ocfs.state.ny.us/main/forms/day_care/ or 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)

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: www.L1Enrollment.com 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

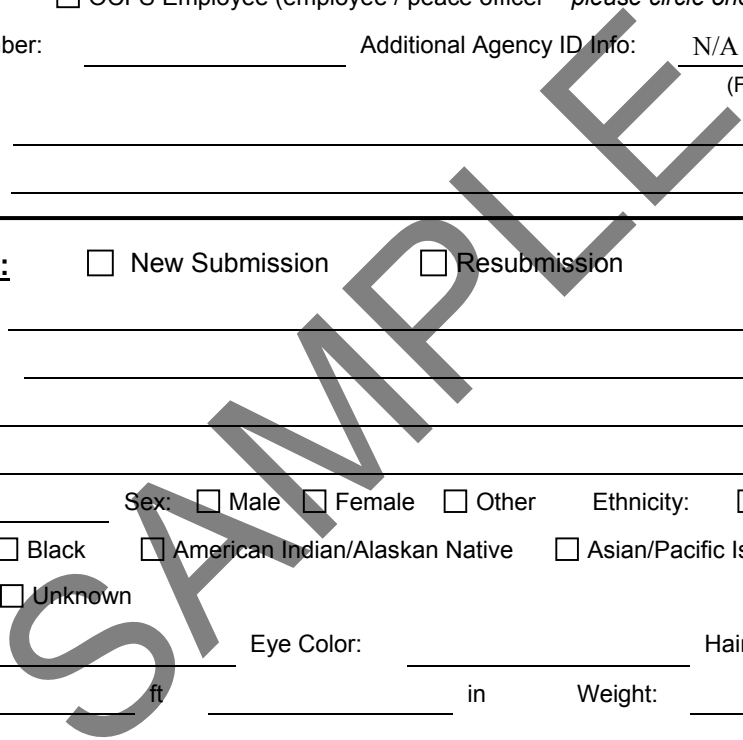
ADOPTION: Adoptive Parent Household Member over 18 yrs

Additional Information: (Foster Care Only)

CONNECTIONS Home Resource ID# N/A

CONNECTIONS Person ID# N/A

Tear Here



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):

<p><u>Column A - Valid Photo Identification:</u></p> <p>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.</p>	<p><u>Column B - Valid Supplementary Identification:</u></p> <p>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)</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Identification if under 18 and nothing else available:

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

Enrollment Website address: www.L1Enrollment.com

Call Center phone number: 877-472-6915

SAMPLE



On-site 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 an educational workshop or course in caring for preschool children.

Child Care Experience

EXAMPLE:	Date Range	Description	Location
	2002 - Present	Parenting	In my home

Date Range	Description	Location

Relevant Training

EXAMPLE:	Date Received	Description	Hours	Sponsoring Organization
	June, 1990	Child Development Workshop	4	Child Care Council

Date Received	Description	Hours	Sponsoring Organization

Additional Qualifications (Optional)

EXAMPLE:	Date(s)	Type	Issued By
	May 2001 – April 2006	CDA	NAEYC

Date(s)	Type	Issued By

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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SAMPLE



On-site 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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SAMPLE



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.

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 <i>(see reverse side for instructions) Attach additional page if necessary.</i>	

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

SAMPLE

SAMPLE

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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

Tear Here

SAMPLE

SAMPLE

This page left blank intentionally.



On-site 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 Duties of Day Care Program

- 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



On-site 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 Mantoux results in the TB section and sign this page

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)

Mantoux 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



On-site 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
	Pett 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 Information

INSTRUCTIONS



Submit

- Each Assistant applying to work in a Group Family Day Care must complete this form and sign the statement below
- Duplicate this form (as needed) for each Assistant
- Each Assistant must be fingerprinted, complete a State Central Register Database Check form and a Criminal History Review, if not already completed as a Household Member
- Assistants must also submit Medical, Reference and Qualification forms for review and approval
- 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)

- 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)

Tear Here

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SAMPLE



Assistant Qualifications

INSTRUCTIONS



Submit

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

Applicant Name:

Assistant 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 an educational workshop or course in caring for preschool children.

Child Care Experience

EXAMPLE:	Date Range	Description	Location
	2002 - Present	Parenting	In my home

Date Range	Description	Location

Relevant Training

EXAMPLE:	Date Received	Description	Hours	Sponsoring Organization
	June, 1990	Child Development Workshop	4	Child Care Council

Date Received	Description	Hours	Sponsoring Organization

Additional Qualifications (Optional)

EXAMPLE:	Date(s)	Type	Issued By
	May 2001 – April 2006	CDA	NAEYC

Date(s)	Type	Issued By

Tear Here

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SAMPLE



Assistant 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:

Assistant 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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SAMPLE



Frequently Asked Questions

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**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?

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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.

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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**

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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.

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES
STATEWIDE CENTRAL REGISTER DATABASE CHECK
Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):
PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:			The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below (see reverse side for instructions) Attach additional page if necessary.	
AGENCY NAME:				
AGENCY LIAISON:				
STREET ADDRESS:				
CITY:	STATE:	ZIP CODE:		

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

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

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

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

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

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

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE
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EIGHTEEN YEARS OLD OR OVER:

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

SIGNATURE	DATE	SIGNATURE	DATE
-----------	------	-----------	------

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:

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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.

SAMPLE

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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	

SAMPLE

Tear Here

SAMPLE

This page left blank intentionally.



Assistant 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: _____

Assistant's Name: _____

Assistant's Date of Birth: _____

Typical Duties of Day Care Program

- 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 (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 Mantoux results in the TB section and sign this page

Applicant Name: _____

Assistant's Name: _____

Assistant's 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)

Mantoux 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

- All Assistants 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: _____

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



Substitute Information

INSTRUCTIONS



Submit



Maintain
On-Site

- *Substitutes are not required, but a program may have as many as needed*
- *Duplicate this form (as needed) for each substitute*
- *All substitutes working in Group Family Day Care must complete this form*
- *Household Members who will function as Substitutes must complete this form*
- *Each substitute must be fingerprinted, complete a State Central Register Database Check form and a Criminal History Review, if not already completed as a Household Member*
- *Please PRINT clearly*

Applicant Name:

Substitute Name:

Definition of a Substitute

A Substitute must be at least 18 years old and can care for children for up to 3 consecutive days. However, a Substitute cannot provide care for more than 15 days or 120 hours in a single year. An example would be a Substitute providing care while the Provider is at a medical appointment.

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

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

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SAMPLE



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

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.

SAMPLE

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SAMPLE

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Substitute Criminal Conviction Statement

INSTRUCTIONS



Submit

- All substitutes 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: _____

Substitute 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



Substitute Conviction Statement (continued)

Applicant Name:

Substitute 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.

SAMPLE



Household Member Medical Statement

INSTRUCTIONS



Submit



Maintain
On-Site

- Each person residing in the home must have a signed medical statement; a separate form is required for Providers
- 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*
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> 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*
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	____/____/____ (mm / dd / yyyy)	<input type="checkbox"/> Yes <input type="checkbox"/> 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

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SAMPLE



Household Member Criminal Conviction Statement

INSTRUCTIONS



Submit

- All household members over age 18 must complete and sign this form regardless of conviction status. Make copies of the form for each person over 18
- 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.

Household Member 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.

SAMPLE



Site Information

Attestation Regarding Bodies of Water C-3

Inspections

Report of Water Supply Testing C-5

Fuel Burning System Inspection..... C-7

Environmental Hazards Guide..... C-10

Environmental Hazards Inspection..... C-11

Use of Space

Inside Floor Plan Guide C-14

Inside Floor Plan..... C-15

Outside Play Area..... C-16

Emergency Plan

Emergency Planning Guide C-18

Emergency Evacuation Plan..... C-19

Emergency Evacuation Diagram Guide..... C-22

Emergency Evacuation Diagram C-23

SAMPLE



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SAMPLE



Attestation Regarding Bodies of Water

INSTRUCTIONS



Submit

- According to Alyssa's Law, special requirements apply to pools and bodies of water
- This form must be completed at time of application and at each renewal
- Please SIGN the bottom of the form

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	
	Yes	No	Yes	No
Above-ground pool.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Deck with access to a body of water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drainage or run-off ditch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hot tub or spa.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In-ground swimming pool.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On-ground swimming pool (wading or inflatable).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ornamental pond, bird bath or fountain.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Private well.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
River, stream, creek, pond or lake	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Statement

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately report the above information may constitute grounds for denial, suspension, limitation or revocation of the license/registration to provide child care at this site. I understand that I must notify the Office of any changes pertaining to the information on this page.

Applicant Signature: _____

Date: ____/____/____
(mm / dd / yyyy)

Tear Here

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SAMPLE



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

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SAMPLE



Fuel Burning System Inspection

INSTRUCTIONS



Submit



Maintain
On-Site

- All applicants must complete this form regardless of inspection requirement
- Sites where any wood, coal, pellet, or other solid fuel-burning stove or fireplace, gas space heater or gas fireplace are used, must have each of these inspected
- Inspections performed within the last 12 months can be attached and submitted with this form
- If you have multiple fuel burning systems requiring inspection, duplicate this form and properly complete one for each system inspection

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,
- Gas space heater,
- Gas fireplace, or
- Wood burning furnace or boiler

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)

Tear Here



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.

SAMPLE



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.state.ny.us/environmental/lead/
Pesticide 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, extension 27556. 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 on the Environmental Hazards Guidance Sheet, pages 3-4, at: www.ocfs.state.ny.us/main/childcare/childcare_forms.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: _____

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.

Tear Here



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.

SAMPLE



Inside Floor Plan Guide

INSTRUCTIONS

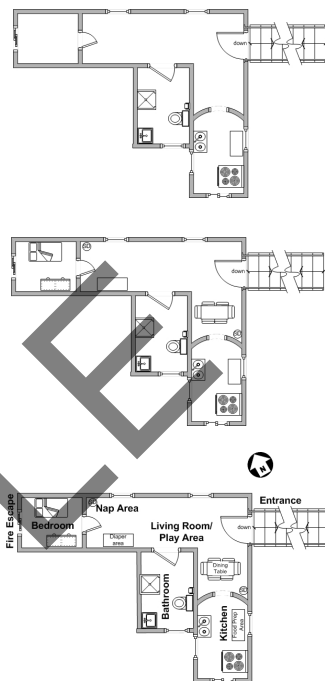
- Please follow the guidelines below when drawing your diagram on the next page

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.

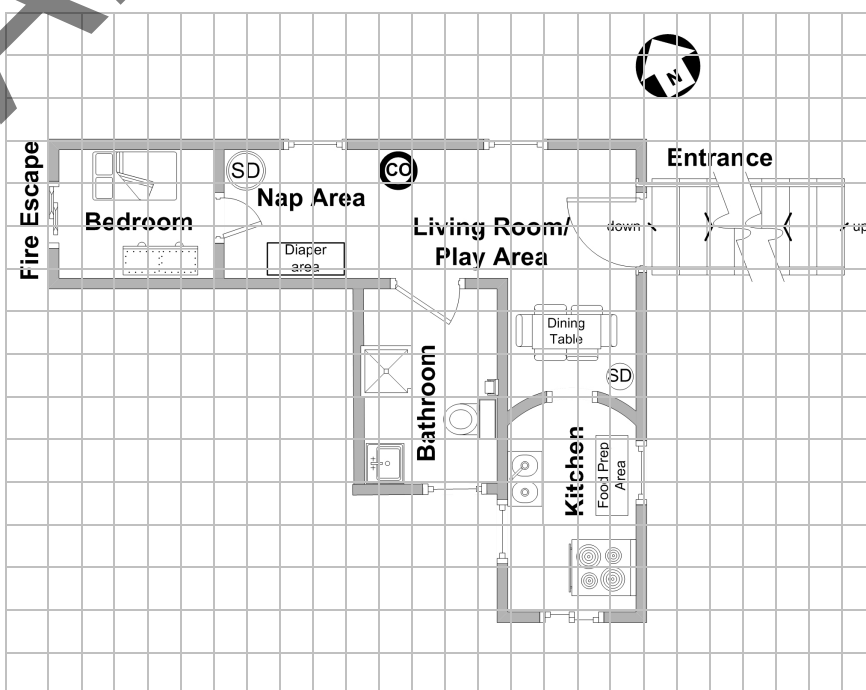
NOTE: Sinks used for food preparation may NOT be used for hand washing following diaper changes.

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:

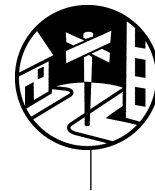
Floor / Apt #:

Grid area for drawing the floor plan. A large watermark reading "SAMPLE" is overlaid diagonally across the grid.

Tear Here

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

SAMPLE



Emergency Planning Guide

INSTRUCTIONS



Maintain
On-Site

- The following pages comprise the Emergency Plan
- 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 posted or 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 should 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:

In certain circumstances it may be necessary to relocate to a site other than your primary relocation site. Consider identifying additional locations within walking distance of your home that are suitable to your program needs.

Other Relocation Sites:

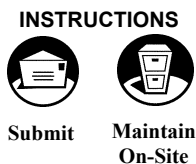
In case of emergency situations requiring evacuation from your home and neighborhood follow instructions of local officials.

Shelter in Place

In some situations it may be necessary to remain on-site while taking special precautions to ensure the safety of the children. This may include keeping children in care beyond normal program hours, or the short-term restriction of movement in or out of the program.



Emergency Plan



- INSTRUCTIONS**
- Use the guide on the previous page to assist you in answering the following questions
 - 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
 - **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 adults 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
- Count the children 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 (continued)

Applicant Name: _____

Notifications

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

Emergency	Backup Numbers		
911	Fire		Ambulance
	Police		Poison Control

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

_____ City _____ Phone No.
Street Address

Transportation Method: _____

Secondary relocation site: _____
Name

_____ City _____ Phone No.
Street Address

Transportation Method: _____

Other relocation site: _____
Name

_____ City _____ Phone No.
Street Address

Transportation Method: _____

Shelter in Place

Describe what arrangements your program will make to prepare to shelter in place, accounting for the needs of the children in care. Consider how will you feed the children and what activities will you use to help keep the children calm.

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

SAMPLE



Emergency Evacuation Diagram Guide

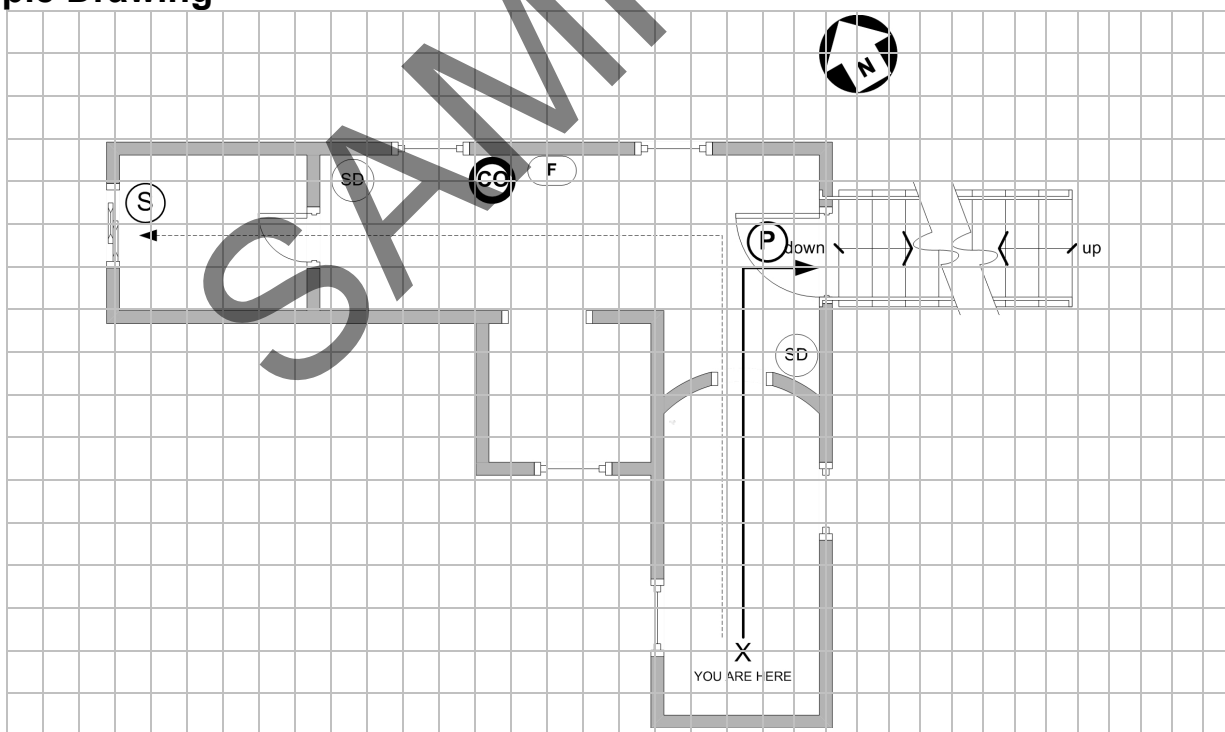
Inside Floor Plan

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 recommended that a copy of the evacuation diagram be posted in each room used for child care. Include the escape path from that room to the nearest exit.

Items Checklist

Item	Symbol
<input type="checkbox"/> Carbon Monoxide Detector	(CO)
<input type="checkbox"/> Smoke Detector	(SD)
<input type="checkbox"/> Exit	(EXIT)
<input type="checkbox"/> Fire Extinguishers	(F)
<input type="checkbox"/> Primary Exit	P →
<input type="checkbox"/> Secondary Exit	S ---→
<input type="checkbox"/> Fire Escapes	(FE)
<input type="checkbox"/> Stairs	
<input type="checkbox"/> You Are Here	X

Sample Drawing





Emergency Evacuation Diagram

INSTRUCTIONS



Submit



Maintain
On-Site

- Follow the guidelines on the opposing page to draw your diagram
- It is highly recommended that you post your emergency diagram alongside the written evacuation plan in a conspicuous place
- Consider posting a diagram in each room used for child care

Applicant Name:

Floor / Apt #:

Grid area for drawing the Emergency Evacuation Diagram. A large diagonal watermark reading "SAMPLE" is overlaid on the grid.

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SAMPLE



Program Information

Behavior Management Guidelines.....D-2
Behavior Management for Child Care.....D-3
Developing Your Program.....D-5
Program Daily ScheduleD-7
Health Care Plan and Guidelines.....D-9

SAMPLE





Behavior Management (Discipline) Guidelines

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. The following are a few suggested web sites:

- www.ocfs.state.ny.us/main/childcare
- www.nysccc.org
- www.nccic.org

Guidelines for 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, lessening the need for discipline. For example, avoid large open spaces that might encourage children to run indoors.
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.

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 punish, 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.



Behavior Management for Child Care

INSTRUCTIONS



Submit



Maintain
On-Site

- Providers are required to have written discipline guidelines to share with parents and staff. Make copies of your guidelines available
- Consider the age and developmental level of the children in developing your guidelines
- 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 discipline techniques so that they are effective with children of different age groups?

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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 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.

(Continued on reverse side)

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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/guardians
- If you have multiple shifts of care, copy and complete this form for each shift
- List the activities for each age group in order they will occur; include times used for naps, meals, outside play, etc.
- 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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SAMPLE



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. Examples: colds, ear infections, or low-grade fevers (a temperature of no more than 101 degrees)
- The child is able to participate in the routines of your day care program with only minor accommodations, such as giving them special foods to eat, more time for naps or quiet play.
- The care of the mildly ill 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)

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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, sunscreen and topically applied insect repellent and not administer any other product or medication. 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 repellent, 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.

WAIVER REGARDING SPECIFIC EMERGENCY MEDICATIONS: Providers may submit to the office a written request for a waiver on forms provided by the office. For non-MAT certified individuals, there are only two conditions for which this waiver may be approved: severe allergic reactions (anaphylactic shock) and asthma. An approved waiver allows a caregiver to administer an epinephrine auto injector, nebulizer and /or inhaler according to the terms of the waiver.

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*
- Request Waiver for Emergency Medications: *additional requirements may apply*
- None



Agreements

Child Support Obligation Statement..... E-3
Applicant Compliance Agreement..... E-5

SAMPLE



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SAMPLE



Child Support Obligation Statement

INSTRUCTIONS



Submit

- **Owner must complete this form unless the business is incorporated**
- *If you are four or more months behind in your child support obligations, General Obligations Law requires that we issue you a registration 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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SAMPLE



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 Part 416 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 Part 416 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.

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.

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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SAMPLE



Appendix

SCR Processing Fee.....	App-3
Nuclear Emergency Planning Zones	App-4
Labor and Tax Responsibilities	App-5
Other Legal Considerations	App-6
List of Regional Offices	App-7

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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 child care Provider also covers all household members over age 18 that do not have a care-giving role. The following is a list of the roles for which a fee is required:

- On-site provider (and all household members)
- Assistant
- Alternate Assistant
- Substitute
- Employee

Please note that 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) 473-0710
	Wayne County Emergency Management Office 7336 Route 31 Lyons, NY 14489 (315) 946-5664

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. The URLs to each Emergency Planning Zone is as follows:

- Indian Point Energy Center:**
www.safesecurevital.org/emergency-preparedness/2008-emergency-planning.html
- Nine Mile Point Nuclear Station:**
www.constellation.com/vcmfiles/Constellation/Files/Emergency-Planning-Zones-NMP.pdf
- James A. Fitzpatrick:**
www.wayneweibel.net/projects/entergy/callcenter_website/site_specific_info/ja_fitzpatrick/ssi_ja_fitzpatrick.htm
- Ginna Nuclear Power Plant:**
www.constellation.com/vcmfiles/Constellation/Files/Emergency-Planning-Zones-GNA.pdf

These sites include (links to) additional information regarding emergency planning and evacuation routes that you might also find helpful.



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.



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.



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
Courthouse Corporate Center
320 Carleton Avenue, Suite 4000
Central Islip, NY 11722
(631) 342-7100

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
Spring Valley, NY 10977
(845) 708-2400

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NYS Office of Children and Family Services
Division of Child Care Services
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