6000 Packet Brief Guide

Note: This is not a complete guide, but an abridged guide to the forms that usually give volunteers the most trouble. All the forms we need from you are highlighted in a rainbow of colors!

OCFS-6001: Basic Info

- CPNYC is classified under All Programs and your role is Volunteer.
- "Out-of-State addresses" refers only to addresses outside of the State of New York, not NYC.
- If you've lived out of NYS in the past 5 years, don't forget the second page!

OCFS-6004: Medical Forms

- If you've had a physical in the previous 12 months, your health care provider can complete these forms using info from your physical. Otherwise, you'll need to schedule an appointment and bring these forms with you.
- Either way, **your health care provider will be completing these forms and sending them to us themselves.** All we need from you is signature and date.

Note: Due to COVID-19, the requirement for these forms is temporarily waived for virtual tutors. It is still required if you intend to come in person.

LDSS-3370 (The tricky one): Address History for the SCR

- As with your out-of-state addresses, make sure all dates are listed consecutively, going in backwards order, **starting with your current address and ending with your first**. This includes any addresses indicated on OCFS-6001!
- **If you're above 28 years of age, you need only to list all addresses you've lived in since 1992. If you're 28 years or younger, you need to list every address you've resided at since birth.** *(Past housemates, Google Maps, and old envelopes or documents can be helpful with this. A free credit score can also give you an address history.)*
- When you're finished, there should be **no gaps between consecutive dates**. This means that the dates indicated next to each address should pick up from where the previous address leaves off.

This is the checklist I use to review your info. Information that's frequently missing/incorrect is in bold.

- ❑ **OCFS-6001 (pg 1)**
  - Have they put the date?
  - Have they checked "Volunteer?"
  - Have they filled out their personal info in full, **including previous names/aliases**?
  - If they checked "yes" to the last question, have they filled out page 2?

- ❑ **OCFS-6001 (pg 2)**
  - Are addresses complete?
  - Are addresses in chronological order?

- ❑ **OCFS-6002**
  - Have they listed any relevant qualifications? (only form ok if blank besides medical)

- ❑ **OCFS-6003**
  - Have they provided one personal and one professional reference?

- ❑ **OCFS-6005**
  - Have they checked a box?
  - Have they signed and dated?

- ❑ **OCFS-6022**
  - Have they filled out the bottom section fully, **including SSN**?

- ❑ **OCFS-4930**
  - Have they filled out the Fingerprint Applicant Section?
  - Have they checked "Volunteer" for Role of Fingerprint Applicant?
  - Have they filled out the Affirmation of Fingerprint Applicant Section?

- ❑ **LDSS-3370**
  - Have they put all of their personal info?
  - If there's no **household member info**, have they checked **the box stating there are no household members?**
  - **Does history go back 28 years?**
  - **Are there any gaps in the dates?**
  - Have they signed and dated?

6000 Packet Brief Guide

***Note: The forms mentioned here are NOT the only forms you need to complete!** These are simply the forms that tend to give applicants the most trouble. The chart on the packet's front page indicates the forms required for a complete application. **

Form numbers are indicated in the upper left corner of each page. The first form you need to fill out is **OCFS-6001**.

- CPNYC is classified under All Programs and your role is Employee/Volunteer.
- Be sure to indicate **all** your previous out-of-state addresses within the previous 5 years. Contact old relatives or roommates to help you with this if needed.
- This applies only to addresses **outside of the State of New York**, not the city.

OCFS-6004 consists of medical information and will be filled out and processed by your health care provider.

- If you've had a physical in the previous 12 months, your health care provider can complete these forms using info from your physical. Otherwise you'll need to schedule an appointment and bring these forms with you.
- Either way, your health care provider will be completing these forms and sending them to us themselves. **All we need from you is signature and date.**

LDSS-3370 is where most people make mistakes that delay processing! Give this form extra attention.

- As with your out-of-state addresses, make sure all dates are listed **consecutively**, going in backwards order, **starting with your current address and ending with your first**. This includes any addresses indicated on OCFS-6001!
- If you're above 28 years of age, you need only to list **all addresses you've lived in since 1992**. If you're 28 years or younger, you need to list **every address you've resided at since birth**. (Again, past housemates, Google Maps, and old envelopes or documents can be helpful with this)
- When you're finished, there should be **no gaps between consecutive dates**. This means that the dates indicated next to each address should pick up from where the previous address leaves off.
  Ex: If your earliest address is dated from 10/94 to 10/97, the address above it should begin at 10/97. If that address is dated from 10/97 to 11/98, the address above it should begin at 11/98, and so on.

OCFS-6000 (Revised 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUIRED FORMS AND CLEARANCE LIST

CHILD CARE PROGRAMS

The requirements for the comprehensive background checks will be completed using the forms listed on the previous page. OCFS will provide written notice as to whether or not the individual is authorized to care for children once the process is complete.

The New York State Criminal History Record Check will be satisfied by using form OCFS-4930. *NYS Department of Criminal Justice Services*
The National Criminal Record Check will be satisfied by using form OCFS-4930. *Federal Bureau of Investigation*
New York State Sex Offender Registry Search (form OCFS-6001) *NYS Department of Criminal Justice Services*
***National Sex Offender Registry Search (form OCFS-4930)** *National Crime and Information Center*
Statewide Central Register Database Check (form LDSS-3370) *SCR of Child Abuse and Maltreatment*
Staff Exclusion List Check (form OCFS-6022) *New York State Justice Center*
State Sex Offender Registry, Child Abuse or Maltreatment, and Criminal History Repository Search (form OCFS-6001) *In each state other than New York where you have lived in the last 5 years*

***required in accordance with a schedule that will be released by the Office of Children and Family Services at a later date**

OCFS- 6001 (Revised 9/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE PROVIDER, STAFF, VOLUNTEER AND HOUSEHOLD MEMBER INFORMATION

CHILD CARE PROGRAMS

Instructions:

- Please **PRINT** clearly. This form MUST be completed by every individual identified on OCFS-6000.
- If you are not sure which role to choose, refer to child day care regulations and/or consult with your licensor, registrar, or legally-exempt enrollment agent.
- List all additional facility ID numbers you want your fingerprints to be associated with.

PROGRAM NAME: Children of Promise, NYC	FACILITY ID NUMBER: 684677
FACILITY ID NUMBER FOR PROGRAMS YOU WANT YOUR FINGERPRINTS ASSOCIATED WITH: , , , , , , , , , , ,	

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care, Small Day Care Centers, Legally-Exempt Informal**	**Day Care Center, School-Age Child Care, Legally-Exempt Group**	**All Programs**
ROLE:	☐ Provider ☐ Substitute (GFDC/FDC) ☐ Assistant (GFDC/FDC) ☐ Household Member	☐ Director ☐ Group Teacher (DCC/SACC) ☐ Assistant Teacher (DCC/SACC) ☐ Teacher (LE GROUP)	☐ Volunteer ☐ Employee

PERSONAL INFORMATION

NAME *(First, MI Last):*		
ADDRESS:	APT:	FLOOR:
CITY:	STATE:	ZIP:
PHONE:	E-MAIL:	
SIGNATURE:	DATE OF BIRTH *(mm/dd/yyyy):* / /	

Have you ever been known by any other name? ☐ Yes ☐ No

If Yes, list all known names (including maiden name, aliases, pseudonyms)

Have you lived outside of New York State in the past five years? ☐ Yes ☐ No

If **YES**, complete page 2 of this form entering all out of state addresses where you lived in the past five years.

If **NO**, you do not have to complete page 2.

APPLICANT NAME: _____

OUT OF STATE ADDRESSES (Previous 5 years)

Print clearly, <u>all</u> dates must be consecutive *(mo/yr)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
				/	/
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OCFS- 6002 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

QUALIFICATIONS

Child Day Care Programs

PROGRAM NAME: Children of Promise, NYC	FACILITY ID NUMBER: 684677
NAME OF PERSON WITH PENDING ROLE:	DATE OF BIRTH (mm/dd/yyyy): / /

The New York State Office of Children and Family Services (OCFS) child day care regulations identify qualifications and minimum requirements for caregiving staff in child day care programs. The information is included in section **.13** of the regulations. Regulations can be obtained at **ocfs.ny.gov** and from your licensor/registrar.

Instructions:

- Consult OCFS regulations for qualification and minimum requirements for your role.
- Complete sections that apply to your role in the program. You may attach a resume.
- You may be asked to submit additional documentation to demonstrate education, training, or child care experience.
- Please **PRINT** clearly

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care and Small Day Care Centers**	**Day Care Center and School-Age Child Care**
ROLE IN PROGRAM	☐ Provider ☐ Volunteer ☐ Assistant ☐ Substitute	☐ Director ☐ Volunteer ☐ Group Teacher ☐ Assistant Teacher

Education/Training (if applicable for pending role)

Date Range	**Degree, Major, Name of Credential, or Training**	**Institution**	**Number of Credits** (if applicable)

Child Care Experience

Date Range	**Description**	**Location**	**Age of Children**

Supervisory Experience (applicable for pending role of Director at Day Care Center/School-Age Child Care program)

Date Range	**Description**	**Location**

OCFS-6003 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REFERENCES

Child Day Care Program

Instructions:

- Please provide complete information for two people (one employment reference and one personal reference) we can contact.
- Relatives may **NOT** be used as references
- If you have been employed outside the home, please include an employer as one of your references
- Please **PRINT** clearly

PROGRAM NAME: Children of Promise, NYC	FACILITY ID NUMBER: 684677
NAME:	

TYPE OF PROGRAM	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care
ROLE IN PROGRAM	☐ Provider ☐ Assistant ☐ Substitute	☐ Director ☐ Teacher ☐ Volunteer

REFERENCE #1 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

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

REFERENCE #2 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

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

REFERENCE #3 (Optional)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME *(Last, First, MI):*		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
- Only a health care provider (physician, physician assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.

Program's Name: Children of Promise, NYC	Facility ID Number: 684677
Person's Name:	Date of Birth: / /

TYPE OF PROGRAM:	**Family Day Care, Group Family Day Care, Small Day Care Centers**	**Day Care Center, School-Age Child Care, Legally-Exempt Group Programs**	**All Programs**
ROLE:	☐ Provider ☐ Substitute ☐ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Group Teacher ☐ Assistant Teacher	☐ Employee ☐ Volunteer

Typical child day care duties

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

Following to be completed by health care provider ONLY

Medical status

To the best of my knowledge of the above-named individual, I find that:			
They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a physical condition that would prevent them from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ NA *(if only role is volunteer or household member)*
For any "YES" responses, clarify and/or indicate restrictions:			

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

Title

Name *(please PRINT clearly or use office stamp)*

Date of Exam

( ) -
Phone

Date of Signature

*(**Continued on reverse side**)*

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Program's Name: Children of Promise, NYC	Facility ID Number:
Person's Name:	Date of Birth:

Instructions:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page. No one with a role in a legally-exempt program needs to complete the turberculin test.
- A health care professional (physician, physician's assistant, nurse practitioner) *or a registered nurse as part of his/her duties at a health care facility*, may enter the results in the tuberculin test Information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please **PRINT** clearly.

Following to be completed by health care professional ONLY

Tuberculin test information

Test completed

Test read on: ____/____/____ (mm / dd / yyyy)

Test result: ☐ Positive ☐ Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Test not completed

☐ Not tested. Provide reason: _____

_____
Medical Exemption or Contraindication

If test result was previously positive, indicate date: ____/____/____ (mm / dd / yyyy)

If previously positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

_____
Signature *(physician, physician's assistant, nurse practitioner or registered nurse)*

_____ _____
Name *(please PRINT clearly or use office stamp)* Title

( ) - ____/____/____
Phone Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs**–return this completed form to your licensor or registrar.
- **DCC/SACC programs-directors**–return this completed form to your licensor or registrar; all other staff–return the form to the director for evaluation.
- **Directors of legally-exempt group programs**–return this form to your enrollment agency.
- **Employees and volunteers at legally exempt programs**–return this form to your director

OCFS-6005 (9//2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CRIMINAL CONVICTION STATEMENT

CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- **ALL** applicants for a licensure or registration, staff, volunteers, and household members 18 years of age or older must complete and sign this Criminal Conviction Statement.
- Please **PRINT** clearly

PROGRAM NAME:	FACILITY ID NUMBER:
Children of Promise, NYC	684677
PERSON'S NAME:	DATE OF BIRTH *(mm/dd/yyyy):*

CERTIFICATION

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 jurisdiction.**

(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.)

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 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):* ___/___/_____

OCFS-6022 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUEST FOR STAFF EXCLUSION LIST CHECK

Child Day Care Programs

PROGRAM NAME: Children of Promise, NYC

FACILITY ID NUMBER: 684677

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked as part of the comprehensive background check process for the individuals identified below and on the **OCFS-6000** form.

Instructions:

- This form is used to check the Justice Center's (SEL).

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

Type of program / Role in the program	Where to submit
Family Day Care, Group Family Day Care and Small Day Care Center (Staff, Volunteers, and Household Members Age 18 and older)	The licensor/registrar of the program
Day Care Center and School-Age Child Care (Directors)	The licensor/registrar of the program
Day Care Center, Legally-Exempt Group Program and School-Age Child Care (Staff and Volunteers)	The director of the program
Legally-Exempt Group Program Directors, Legally-Exempt Informal Child Care (Providers, Staff, Volunteers, and Household Members Age 18 and older)	The Enrollment Agency of the program

If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information below. Please **PRINT** clearly to avoid delays in processing.

First name: _____

Last name: _____

Middle initial:

Social security number: ___ - ___ - _____

Date of birth *Only if no social security number or alien registration number is available:* ___ / ___ / _____

Alien registration number *Only if no social security number is available*: _____

Position applied for: _____

Fingerprint Applicant Info Sheet

Applicant Name First Name_____ Last Name_____

Applicant Date of Birth _____

Methods of Contact *(Include contact information for who should be notified if the applicant needs to be reprinted if there is a problem with the prints. This can be the Authorized Person.)*

Preferred Contact Method (check one): Phone☐ Email☐

Phone Number _____

Email_____(*not required unless preferred method of contact)*

Applicant Citizenship

Country of Birth: _____

If US, state of birth: _____ City of Birth: _____

Country of Citizenship: _____

Applicant Personal Questions

Have you ever used a maiden/previous name? Yes ☐ No ☐

Have you ever used an alias? Yes ☐ No ☐

Is your mailing address the same as your residential address? Yes ☐ No ☐

Applicant Personal Info

Height: ___ Feet ___ Inches Weight: ____

Eye Color:	Hair Color:	
Black	Bald	White
Blue	Black	Blue
Brown	Blond or Strawberry	Green
Gray	Brown	Orange
Green	Gray	Pink
Hazel	Red or Auburn	Purple
Maroon	Sandy	Unknown
Pink		
Multicolored		
Unknown		

Preferred language: _____ Gender: Male☐ Female☐ Race:

- Asian
- Black
- Native American
- Caucasian/Latino
- Unknown

Ethnicity:☐Hispanic ☐ Non-Hispanic ☐ Unknown

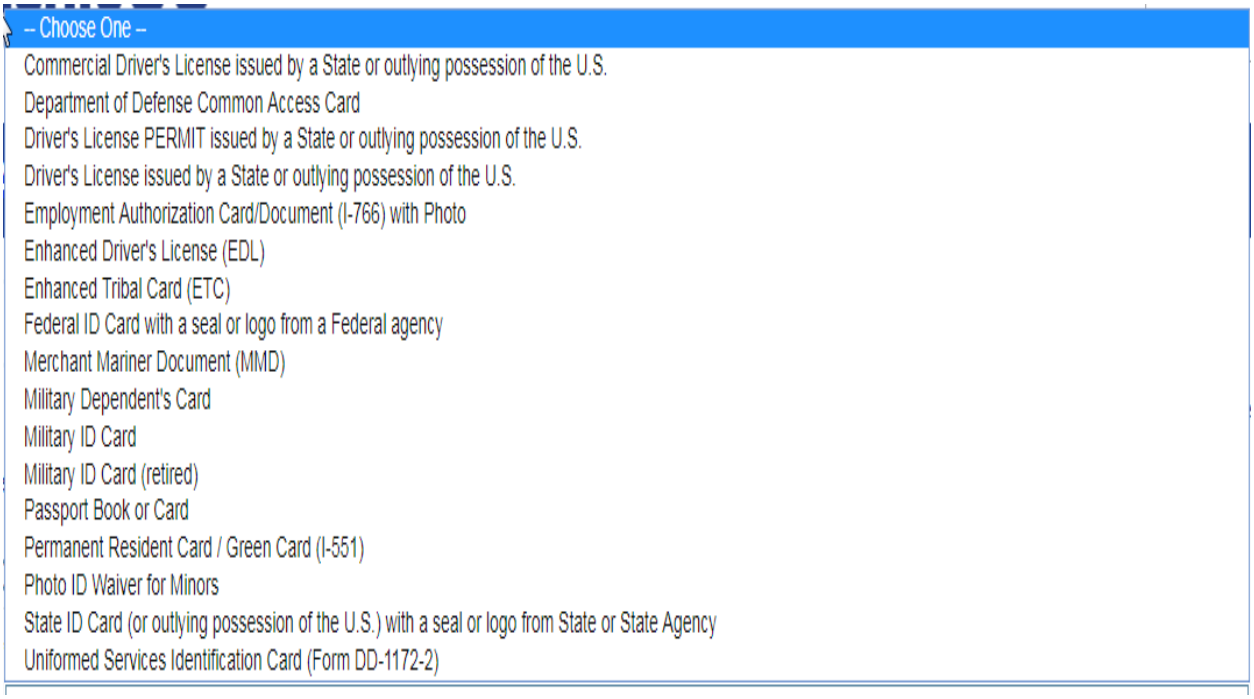
Applicant Home Address Number_____ Street Name_____

Unit Designator (Apt # **required** If applicable) _____

Country_____ City_____ State_____ Zip Code_____

Applicant Identification Document

Please select the required documents the Applicant will bring to the fingerprint appointment.



Does the name you are enrolling the Applicant under match the name on the document selected?

PLEASE NOTE: THE FINGERPRINT LOCATION WILL NOT ACCEPT TEMPORARY OR EXPIRED IDENTIFICATION DOCUMENTS.

Dates and Times Applicant will be available for a fingerprint appointment?

NEW YORK STATE OF OPPORTUNITY. Justice Center for the Protection of People with Special Needs	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	**NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit**

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee ☐ Volunteer ☐ Family Care ☐ Operator ☐	
Applicant address, city state:	Social Security Number:	
Facility/Provider Name:		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   (a) ☐ have not been convicted of a crime.
   (b) ☐ have been convicted of a crime in NY or other jurisdiction.
   (c) ☐ have pending arrest charges.
   If (b) or (c) is checked, provide details:_____

   _____

   _____

   _____

You have not been convicted of a crime if:
a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
b. you received an Adjournment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

Applicant Signature		Date:
Guardian signature if under 18		Date:
Part 3	**Facility or Provider Agency Authorized Person Information**	
Authorized Person Name:		Title:
Signature:		Email:

LDSS-3370 (Rev. 08/2019) DCCS version FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE:	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY (Use alpha codes on reverse):	PHONE NUMBER (Area Code):
				( ) -

PRINT BELOW THE ADDRESS ASSOCIATED WITH YOUR RID/CCFS NUMBER:

AGENCY NAME: Children of Promise, NYC

AGENCY LIAISON: Melissa Lopez, Human Resources Manager

STREET ADDRESS: 54 Macdonough Street

CITY: Brooklyn **STATE:** NY **ZIP CODE:** 11216

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/MARRIAGE 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 NYS 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**

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	Sex M/F	DATE OF BIRTH
APPLICANT			☐ M ☐ F	
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

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

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM (Mo/Yr) /	TO (Mo/Yr) /

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 OF AGE OR OLDER:

I understand that as a person 18 years of age or older in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider or a legally-exempt in-home or family child 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 / /

STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: _____

Print clearly, all dates must be consecutive *(month/year)*. Be sure to associate address histories with particular individuals.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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STAPLE TO LDSS-3370, DCCS version *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM

ADDITIONAL PAGE

(Use only if the space on the form, **LDSS-3370,** DCCS version is not sufficient)

APPLICANT NAME: _____

Other Household Members are: (please print clearly):

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

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