

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**REQUIRED FORMS AND CLEARANCE LIST**  
**CHILD CARE PROGRAMS**

The following individual forms listed must be completed for all staff, legally exempt providers, volunteers and all household members 18 years of age or older as noted in the chart below:

- **DCC, SACC and Legally Exempt Group Program Staff and Volunteers:** Submit all required forms listed below to your Director. Director or designee enters the information from the **LDSS-3370** form into the Online Clearance System (OCS). If payment is not made with credit card, the \$25.00 payment, in the form of certified check or money order, must be mailed to OCFS- Finance Dept. 52 Washington Street, Room 203 South, Rensselaer, New York, 12144. Your clearances will **NOT** be processed without payment. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. All clearance documents are then submitted to the Licensor/Registrar or Enrollment Agency. Director checks references and qualifications for DCC and SACC staff/volunteers.
- **DCC, SACC and Legally Exempt Group Program Directors:** Submit all required forms listed below to your Licensor/Registrar or Enrollment Agency along with SCR payment. Your clearances will **NOT** be processed without payment. Schedule an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. All clearance documents are then submitted to the Licensor/Registrar or Enrollment Agency.
- **All GFDC/FDC/SDCC Staff and Household Members:** Submit all required forms listed below to your Licensor/Registrar. Your clearances will **NOT** be processed without payment. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment (if noted below).
- **Legally Exempt Informal Child Care Providers\*, Staff and LE Family Child Care Household Members 18 and older\*\*:** Submit all required forms listed below to your Enrollment Agency. Make an appointment for fingerprinting using the **OCFS-4930** and bring that form to the appointment. Your clearances will **NOT** be processed without payment

\*Legally exempt informal child care providers who are related to ALL children in care as a grandparent, great grandparent, sibling (who resides in a separate residence), aunt or uncle are exempt from comprehensive background check requirements, as are their staff and volunteers.

\*\*Legally exempt family child care household members age 18 or older who are related to ALL children in care in any way are exempt from comprehensive background check requirements.

Requirement	All Staff and Volunteers in licensed/ registered programs	G/FDC Household Member 18 Years and Older	G/FDC Household Member Under 18 years old	Legally Exempt Group Staff and Volunteers	Legally Exempt Informal Providers, Staff, Volunteers and LE Child Care Household Members 18 years and older
<b><u>LDSS-3370</u></b> Statewide Central Register Database Check (includes the form and instructions for completing the DCCS version)	X	X		X	X
<b><u>OCFS-4930</u></b> Request for Fingerprinting Services-Child Care	X	X		X	X
<b><u>OCFS-6001</u></b> Child Care Provider, Staff, Volunteer, and Household Member Information	X	X	X	X	X
<b><u>OCFS-6002</u></b> Qualifications	X				
<b><u>OCFS-6003</u></b> References	X				
<b><u>OCFS-6004</u></b> Child Care Provider, Staff, Volunteer, and Household Member Medical Statement	X	X	X	X	
<b><u>OCFS-6005</u></b> Criminal Conviction Statement	X	X			
<b><u>OCFS-6022</u></b> Request for Staff Exclusion List Check	X	X		X	X

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.

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

\* **Privacy Act Statement:** This privacy act statement is located on the back of the FD-258 fingerprint card.

**Authority:** The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

**Principal Purpose:** Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

**Routine Uses:** During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

As of 03/30/2018

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

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 each applicant for child care provider, staff, volunteer and household member.
- If you are not sure which role to choose, refer to the child day care regulations and/or consult with your licensor, registrar, or legally-exempt enrollment agent.
- **List all other facility ID numbers you want your fingerprints to be associated with.**

**PROGRAM INFORMATION**

PROGRAM NAME:		FACILITY ID NUMBER:
FACILITY ID NUMBER OF PROGRAMS YOU WANT YOUR FINGERPRINTS ASSOCIATED WITH: , , , , , , , , , , ,		
BUSINESS CONTACT NAME:		
PHONE NUMBER: ( ) -	EMAIL ADDRESS:	

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:	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute (GFDC/FDC) <input type="checkbox"/> Assistant (GFDC/FDC) <input type="checkbox"/> Household Member	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher (DCC/SACC) <input type="checkbox"/> Assistant Teacher (DCC/SACC) <input type="checkbox"/> Teacher (LE GROUP)	<input type="checkbox"/> Volunteer <input type="checkbox"/> Employee

**PERSONAL INFORMATION**

FULL NAME (First, Middle, Last):			
DATE OF BIRTH:		GENDER:	
ADDRESS:		APT:	FLOOR:
CITY:		STATE:	ZIP:
PHONE NUMBER:	EMAIL ADDRESS:		

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 in another U.S. state or territory outside of NYS in the last 5 years? Prior residence in another country does not apply.  YES  NO

If **YES**, complete page 2 of this form entering all out of state addresses, including U.S. territories where you lived in the past five years. **Additional information and/or forms may be required.**

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

APPLICANT NAME: \_\_\_\_\_

\*APPLICANT SOCIAL SECURITY NUMBER (voluntary): \_\_\_\_\_

APPLICANT EMAIL: \_\_\_\_\_

**OUT OF STATE ADDRESSES (Previous 5 years)**

- PRINT CLEARLY
- YOU MAY BE ASKED TO SUBMIT ADDITIONAL FORMS FOR OUT OF STATE CLEARANCES.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
				/	/
				/	/
				/	/
				/	/
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				/	/

**\*Social Security Account Number (SSAN):** Pursuant to the Privacy Act of 1974, any federal, state, or local government agency that requests an individual to disclose his or her SSAN, is responsible for informing the person whether disclosure is mandatory or voluntary, by what statutory or other authority the SSAN is solicited, and what uses will be made of it. In this instance the SSAN is solicited pursuant to 42 USC §9858f and New York State Social Services Law §390-b and will be used as a unique identifier to confirm your identity with other states and territories because many people have the same name and date of birth. Disclosure of your SSAN is voluntary; however, failure to disclose your SSAN may affect completion or approval of your application.

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**QUALIFICATIONS**  
**Child Day Care Programs**

PROGRAM NAME:	FACILITY ID NUMBER:
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](http://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

<b>TYPE OF PROGRAM:</b>	<b>Family Day Care, Group Family Day Care and Small Day Care Centers</b>	<b>Day Care Center and School-Age Child Care</b>
<b><u>ROLE IN PROGRAM</u></b>	<input type="checkbox"/> Provider <input type="checkbox"/> Volunteer <input type="checkbox"/> Assistant <input type="checkbox"/> Substitute	<input type="checkbox"/> Director <input type="checkbox"/> Volunteer <input type="checkbox"/> Group Teacher <input type="checkbox"/> 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

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:	FACILITY ID NUMBER:
NAME:	

<b><u>TYPE OF PROGRAM</u></b>	<b>Family Day Care, Group Family Day Care and Small Day Care Centers</b>	<b>Day Care Center and School-Age Child Care</b>
<b>ROLE IN PROGRAM</b>	<input type="checkbox"/> Provider <input type="checkbox"/> Assistant <input type="checkbox"/> Substitute	<input type="checkbox"/> Director <input type="checkbox"/> Teacher <input type="checkbox"/> Volunteer

**REFERENCE #1 (Required)**

Please check appropriate reference type:  Personal  Employment

<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.	NAME ( <i>Last, First, MI</i> ):		
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

<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.	NAME ( <i>Last, First, MI</i> ):		
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

<input type="checkbox"/> MR. <input type="checkbox"/> MRS. <input type="checkbox"/> MS.	NAME ( <i>Last, First, MI</i> ):		
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 only 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:	Facility ID Number:
Person's Name:	Date of Birth: / /

<u>TYPE OF PROGRAM:</u>	Family Day Care, Group Family Day Care, Small Day Care Centers	Day Care Center, School-Age Child Care, Legally Exempt Group Programs	All Programs
<b>ROLE:</b>	<input type="checkbox"/> Provider <input type="checkbox"/> Substitute <input type="checkbox"/> Assistant <input type="checkbox"/> Household Member (GFDC/FDC)	<input type="checkbox"/> Director <input type="checkbox"/> Group Teacher <input type="checkbox"/> Assistant Teacher	<input type="checkbox"/> Employee <input type="checkbox"/> Volunteer

**Typical child day care duties**

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

**Following to be completed by health care provider ONLY**

**Medical status**

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

\_\_\_\_\_  
Signature (physician, physician assistant, nurse practitioner)

\_\_\_\_\_  
Name (please PRINT clearly or use office stamp)

(     )     -  
Phone

\_\_\_\_\_  
Title

/ /

\_\_\_\_\_  
Date of Exam

/ /

\_\_\_\_\_  
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:  
Person's Name:

Facility ID Number:  
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 tuberculin test.
- A health care professional (physician, physician 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 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



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:
PERSON'S NAME:

FACILITY ID NUMBER:
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): \_\_\_\_ / \_\_\_\_ / \_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**REQUEST FOR STAFF EXCLUSION LIST CHECK**  
**Child Day Care Programs**

PROGRAM NAME:

FACILITY ID NUMBER:

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, REQUIRED FORMS AND CLEARANCE LIST** 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:** \_\_\_\_\_

NEW YORK STATE  
OFFICE OF CHILDREN AND FAMILY SERVICES  
**REQUEST FOR NYS FINGERPRINTING SERVICES**  
**Child Care Programs**

**Enrollment Information:**

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

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

**Website:** <https://uenroll.identogo.com/workflows/15441V> or the **Call Center: 877-472-6915**

**Contributor Agency Section:**

Service Code: 15441V Contributor Agency: NYS Office of Children and Family Services-Child Day Care Programs

Facility/Agency ID Number: \_\_\_\_\_

Facility Name/Address: \_\_\_\_\_

**Fingerprint 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 Fingerprint Applicant (please check one):**

**CHILD CARE:**    Director (D)    Provider (F)    Employee/Teacher (T)    Volunteer (V)  
 Household Member over the age of 18 (HM)

**Fingerprint Applicant Affirmation Section**

I hereby affirm that the information contained in the application and the supporting documents are true and do not contain any false statements or omissions of any material information or facts. I understand that the making of false written statements in this application is punishable as a class A misdemeanor under Section 175.30 and/or Section 210.45 of the New York Penal Law.

Applicant's signature: **X**

Date:    /    /    

**Payment Section:**

Agency Billing Account

**Accepted Forms of Identification to bring to your appointment (must be valid and not expired):**

- Driver license issued by a state or outlying possession of the United States, U.S.
- Driver license PERMIT issued by a state or outlying possession of the U.S.
- ID card issued by a federal, state, or local government agency or by a territory of the U.S.
- State ID card (or outlying possession of the U.S.) with a seal or logo from state or state agency
- Commercial driver license, issued by a state or outlying possession of the U.S.
- Department of defense common access card
- Employment authorization document that contains a photograph
- Foreign driver license (Mexico and Canada only)
- Foreign passport
- Military dependent's identification card
- Permanent resident card or alien registration receipt card (form I-551)
- U.S. Coast Guard Merchant Mariner Credential
- U.S. Military identification card
- U.S. passport
- U.S. Tribal card (enhanced only) or U.S. Bureau of Indian Affairs identification card
- U.S. visa issued by the U.S. Department of Consular Affairs for travel to or within, or residence within, the U.S.
- Uniformed Services identification card (form DD-1172-2)

**Identification if under 18 and nothing else available:**

Persons under the age of 18 who are unable to present an acceptable photograph document listed above shall provide a Social Security card or a birth certificate. The [New York Photo ID Waiver for Minors](#), developed by the New York State Division of Criminal Justice Services, must be completed and signed by a parent or guardian at the time of fingerprinting at the fingerprinting site location.

**Do not sign this form in advance.**

***NOTE:*** Staff with fingerprint images on file with OCFS may be eligible for a waiver. Contact the licensor/registrar or director of the program for more information.

**Hard-to-Print Applicants**

**Please contact the Criminal History Review Unit at 518-473-8595 for instructions.**

**Federal Bureau of Investigation Privacy Act Statement:**

**Privacy Act Statement:** This privacy act statement is located on the back of the FD-258 fingerprint card.

**Authority:** The FBI's acquisition, preservation, and exchange of fingerprints and associated information is generally authorized under 28 U.S.C. 534. Depending on the nature of your application, supplemental authorities include Federal statutes, State statutes pursuant to Pub. L. 92-544, Presidential Executive Orders, and federal regulations. Providing your fingerprints and associated information is voluntary; however, failure to do so may affect completion or approval of your application.

**Principal Purpose:** Certain determinations, such as employment, licensing, and security clearances, may be predicated on fingerprint-based background checks. Your fingerprints and associated information/biometrics may be provided to the employing, investigating, or otherwise responsible agency, and/or the FBI for the purpose of comparing your fingerprints to other fingerprints in the FBI's Next Generation Identification (NGI) system or its successor systems (including civil, criminal, and latent fingerprint repositories) or other available records of the employing, investigating, or otherwise responsible agency. The FBI may retain your fingerprints and associated information/biometrics in NGI after the completion of this application and, while retained, your fingerprints may continue to be compared against other fingerprints submitted to or retained by NGI.

**Routine Uses:** During the processing of this application and for as long thereafter as your fingerprints and associated information/biometrics are retained in NGI, your information may be disclosed pursuant to your consent, and may be disclosed without your consent as permitted by the Privacy Act of 1974 and all applicable Routine Uses as may be published at any time in the Federal Register, including the Routine Uses for the NGI system and the FBI's Blanket Routine Uses. Routine uses include, but are not limited to, disclosures to: employing, governmental or authorized non-governmental agencies responsible for employment, contracting, licensing, security clearances, and other suitability determinations; local, state, tribal, or federal law enforcement agencies; criminal justice agencies; and agencies responsible for national security or public safety.

## Instructions for Completing the Statewide Central Register

### Database Check Form LDSS-3370, DCCS version

ALL information on the LDSS-3370, DCCS version must be easily read so that data entry and results are accurate. Each *Statewide Central Register Database Check form LDSS-3370, DCCS version* 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.

#### HOW 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.)
- Day Care providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of RID number. (Contact your licensing agency/regional office if you have any questions).
- Clearance Category letter code (see the back of form LDSS-3370, DCCS version) 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 and city

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#### 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 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, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.**

- First column: indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: check either M (Male) or F (Female) for every person listed.
- Date of Birth column: fill in complete date of birth (mm/dd/yyyy) for everyone listed on the form.

##### ADDRESS AREA

The information required varies depending on the category (see the back of the form for categories).

- For Adoption, Foster Care and Family and Group Family Day Care, provide addresses for the applicant and any household member who is 18 years of age or older. For legally-exempt Family Child Care provide addresses for the applicant and any household member who is 18 years of age or older, unless the household member is related in any way to all children in care. **This information must date back to the last 28-years.** Attach supplemental pages if necessary, but **do not use** another LDSS-3370, DCCS version form to list this additional information. Be sure to associate address histories with individuals (i.e., indicate which addresses are for which household member).
- For all other categories, only the applicant's address history is required – for the **last 28-years**.
- Complete addresses are required. Include street name, street number, apartment number and city/town/village. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates (*months/years*) of residence. If the applicant has spent time in the military, list base names and locations along with dates (*months/years*).
- **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, DCCS version for this additional information.

##### SIGNATURE AREA

- Signatures required depend upon the category (see the back of the form for categories).
- For Adoption, Foster Care and Family and Group Family Day Care, signatures are needed from the applicant and any household member who is 18 years of age or older. For legally-exempt Family Child Care, signatures are needed from the applicant and any household member who is 18 years of age or older unless the household member is related in any way to all children in care.
- 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 years of age 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/yyyy). **The SCR will not accept** a form with a signature date more than six-months old.

If you have questions regarding completion of this form, **please call the SCR at 518-474-5297.**

**SUBMIT YOUR COMPLETED LDSS-3370, DCCS VERSION TO THE PERSON REFERENCED IN OCFS-6000  
INCLUDE THE REQUIRED FEE FOR EACH APPLICANT FOR EMPLOYMENT/TO BE A CHILD CARE PROVIDER**

#### TO ORDER A SUPPLY OF FORM, LDSS-3370, DCCS version:

Please access the OCFS-4627, *Request for Forms and Publications*, from the Intranet: [https://ocfs.state.nyenet/admin/forms/Management\\_Services/](https://ocfs.state.nyenet/admin/forms/Management_Services/)

Internet [https://ocfs.ny.gov/main/documents/forms\\_keyword.asp](https://ocfs.ny.gov/main/documents/forms_keyword.asp) and mail the completed OCFS-4627, *Request for Forms and Publications* to: THE NEW YORK STATE OFFICE OF CHILDREN AND FAMILY SERVICES, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 116 SOUTH BLDG., RENSSELAER, NY 12144.

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

<b>SCR USE ONLY</b>
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: <b>AGENCY NAME:</b> _____ <b>AGENCY LIAISON:</b> _____ <b>STREET ADDRESS:</b> _____ <b>CITY:</b> _____ <b>STATE:</b> _____ <b>ZIP CODE:</b> _____			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.  <b>FOR ALL CATEGORIES:</b> Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. <b>MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS/MARRIAGE SECTIONS THAT APPLY. IF NONE, STATE "NONE" List RELATIONSHIP in the fields below.</b> (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		
				mm	dd	yyyy
APPLICANT			<input type="checkbox"/> M <input type="checkbox"/> F			
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> F			
			<input type="checkbox"/> M <input type="checkbox"/> 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 and legally-exempt Family Child 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 (mm/dd/yyyy) / /
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APPLICANT'S SIGNATURE	DATE (mm/dd/yyyy) / /
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**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 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 (mm/dd/yyyy) / /
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SIGNATURE	DATE (mm/dd/yyyy) / /
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## 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 18 years of age or older 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 three-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 three-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 RID number. (Contact your licensing agency/regional office if you have any questions).

**RESOURCE I.D. (RID):** Record your RID in this field. OCFS, OMH, OMRDD, DOH, OASAS and SED licensed agencies and programs and local departments of social services, have RIDs as of 9/2001. Verify your RID with your licensing agency. If you need assistance, email: [ocfs.sm.conn\\_app@ocfs.ny.gov](mailto:ocfs.sm.conn_app@ocfs.ny.gov)

**CLEARANCE CATEGORIES:** Record the appropriate alpha code in the category box.

<p><b>A</b>–Adult Services/Family Type Home for Adults</p> <p><b>CCE</b>–Child Care Current Employee</p> <p><b>CCZ</b>–Child Care Prospective Volunteer/Consultant</p> <p><b>CCS</b>–Child Care Provider of Goods/Services</p> <p><b>D</b>–Prospective employee (<i>Local DSS district - bill against reimbursement</i>) **</p> <p><b>F</b>–Prospective/new employee other than day care employees. (fee required - see below) *</p> <p><b>G</b>–This is a provider or employee, at legally-exempt in-home child care who does not reside in the home. No checks required when provider is a legally-exempt relative-only in-home child care provider.  (This category is only to be used by Enrollment Agencies) (fee required - see below) *</p> <p><b>I</b>–This is a provider, at legally-exempt family child care. No checks required when provider is a legally-exempt relative-only family child care provider. (This category is only to be used by Enrollment Agencies) (fee required - see below) * For providers, include address history for all household members 18-years old or over who are not related in any way to all children in care.</p> <p><b>J</b>–Age 18 or Older Household Member (with no child care role)</p>	<p><b>L</b>–This is a director or employee at legally exempt group child care. (This category is only to be used by Enrollment Agencies). (fee required - see below) *</p> <hr/> <p><b>M</b>–Director of a summer camp, overnight camp, day camp or traveling day camp.</p> <p><b>N</b>–Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below) *</p> <p><b>P</b>–Applying to be a family day care provider. (<i>fee required - see below</i>) * <i>Provide address history for all household members 18-years old or over.</i></p> <p><b>Q</b>–Applying to be group family day care provider. (<i>fee required - see below</i>) * <i>Provide address history for all household members 18 years old or over.</i></p> <p><b>R</b>–Applying to be kinship foster parents.</p> <p><b>U</b>–Universal Pre-K Teacher (fee required - see below) *</p> <p><b>W</b>–Applying to be foster parents or family care home providers.</p> <p><b>X</b>–Applying to be adoptive parents pursuant to an application pending before the inquiring agency.</p> <p><b>Y</b>–Prospective <u>Day Care</u> employee (<i>fee required - see below</i>) * –Applying to be a Group Family Day Care Assistant. (fee required - see below) *  Prospective employee of legally-exempt family child care (fee required-see below) *</p>
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**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):** -USE FIRST LINE (at least one person must be so designated)

**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 THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.**

\*Social Services Law 424-a(1)(f) requires the collection of a **\$25.00 fee** for applicants for employment and applicants to be a child care provider. 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 must also include the applicant's name and the agency code.

**N.B.:** a separate check must accompany each form.

\*\*Social Services Law 424-a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, please call the SCR at 518-474-5297.

**SUBMIT YOUR COMPLETED FORM, LDSS-3370, DCCS VERSION TO THE PERSON REFERENCED IN OCFS-6000  
INCLUDE THE REQUIRED FEE FOR EACH APPLICANT FOR EMPLOYMENT/TO BE A CHILD CARE PROVIDER**





