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 & Volunteers in licensed/ registered programs | G/FDC Household Member 18 Years & 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 & older |
|---|---|---|---|---|---|
| **LDSS-3370** *Statewide Central Register Database Check (includes the form and instructions for completing the DCCS version)* | X | X | | X | X |
| **OCFS-4930** *Request for Fingerprinting Services-Child Care* | X | X | | X | X |
| **OCFS-6001** *Child Care Provider, Staff, Volunteer, and Household Member Information* | X | X | X | X | X |
| **OCFS-6002** *Qualifications* | X | | | | |
| **OCFS-6003** *References* | X | | | | |
| **OCFS-6004** *Child Care Provider, Staff, Volunteer, and Household Member Medical Statement* | X | X | X | X | |
| **OCFS-6005** *Criminal Conviction Statement* | X | X | | | |
| **OCFS-6022** *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.

| |
|---|
| **The New York State Criminal History Record Check will be satisfied by using form OCFS-4930.**<br>*NYS Department of Criminal Justice Services* |
| **The National Criminal Record Check will be satisfied by using form OCFS-4930.**<br>*Federal Bureau of Investigation* |
| **The New York State Sex Offender Registry Search will be satisfied by using form OCFS-6001.**<br>*NYS Department of Criminal Justice Services* |
| **The National Sex Offender Registry Search*** will be satisfied by using form OCFS-4930.**<br>*National Crime and Information Center* |
| **The Statewide Central Register Database Check will be satisfied using form LDSS-3370.**<br>*SCR of Child Abuse and Maltreatment* |
| **The Staff Exclusion List Check will be satisfied by using form OCFS-6022.**<br>*New York State Justice Center* |
| **The State Sex Offender Registry, Child Abuse or Maltreatment, and Criminal History Repository Search will be satisfied by using form OCFS-6001.**<br>*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*

NEW YOUR 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: | ☐ Provider<br>☐ Substitute (GFDC/FDC)<br>☐ Assistant (GFDC/FDC)<br>☐ Household Member | ☐ Director<br>☐ Group Teacher (DCC/SACC)<br>☐ Assistant Teacher (DCC/SACC)<br>☐ Teacher (LE GROUP) | ☐ Volunteer<br>☐ 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.

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# 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** 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.

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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:** ______________________________

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# GUIDELINES FOR FINGERPRINTING

## Child Care Programs

**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.**

In order to comply with the federal comprehensive background clearance checks effective 2019, fingerprinting is required for all prospective and existing: operators, directors, employees, volunteers and household members age 18 or older in licensed/registered programs; and legally-exempt directors, in-home and family providers, employees, volunteers and family child care household members age 18 or older not related in any way to all children in care.

1. To be fingerprinted for OCFS, you must go to an authorized digital imaging center in New York State.
   - Complete the *Request for NYS Fingerprinting Services* form (OCFS-4930).
   - Schedule an appointment by calling 1-877-472-6915 or by going to the following website: https://uenroll.identogo.com/workflows/15441V.
   - You can select the location for your fingerprinting when you schedule your appointment.
2. 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 care purposes:
   - 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/enrollment number assigned to the program for which you are applying.
   - You must complete the "Applicant" section with your own information. For the purposes of this form, "Applicant" means the person to be fingerprinted.
   - You must also select the appropriate role in the "Child Care/Role of Applicant" section.
3. On the day of the fingerprinting appointment:
   - You must bring the accepted forms of identification (ID) listed on the back of form OCFS-4930. No one will be fingerprinted without appropriate ID. The forms of identification must be valid and not expired.
   - Your picture will be taken and your identification will be validated.
   - You will be required to data enter your Social Security number if one has been issued to you.

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

If you have additional questions, please contact your regulator or enrollment agency.

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# 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: ______________________

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**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: ______________________

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**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)

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**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

# 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

## 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. **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 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**
BE SURE TO INCLUDE THE REQUIRED FEE - **FEE REQUIRED FOR EACH APPLICANT**

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

Please access the **OCFS-4627,** *Request for Forms and Publications*, from the Intranet: http://ocfs.state.nyenet/admin/forms/Management_Services/ Internet http://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.**

**SCR USE ONLY**

REQUEST I.D.:

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

# STATEWIDE CENTRAL REGISTER DATABASE CHECK

*Agency Use Only*

**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:** ______

**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/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 mm | dd | yyyy |
|---|---|---|---|---|---|---|
| APPLICANT | | | ☐ M ☐ F | | | |
| APPLICANT MAIDEN/ALIAS/ MARRIED NAME | | | ☐ M ☐ F | | | |
| | | | ☐ M ☐ F | | | |
| | | | ☐ M ☐ F | | | |
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| | | | ☐ 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 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) / / | APPLICANT'S SIGNATURE | DATE (mm/dd/yyyy) / / |
|---|---|---|---|

**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) / / | SIGNATURE | DATE (mm/dd/yyyy) / / |
|---|---|---|---|

# 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

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

| | |
|---|---|
| A–Adult Services/Family Type Home for Adults<br>CCE - Child Care Current Employee<br>CCZ - Child Care Prospective Volunteer/Consultant<br>CCS - Child Care Provider of Goods/Services | L–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) * |
| D–Prospective employee *(Local DSS district - bill against reimbursement)* ** | M–Director of a summer camp, overnight camp, day camp or traveling day camp. |
| F–Prospective/new employee other than day care employees. (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) * |
| G–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–Applying to be a family day care provider. *(fee required - see below) * Provide address history for all household members 18- years old or over.*<br>Q–Applying to be group family day care provider. *(fee required - see below) * Provide address history for all household members 18 years old or over.*<br>R–Applying to be kinship foster parents.<br>U-Universal Pre-K Teacher (fee required - see below)*<br>W–Applying to be foster parents or family care home providers. |
| I–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) *<br>J–Age 18 or Older Household Member (with no child care role) | X–Applying to be adoptive parents pursuant to an application pending before the inquiring agency.<br>Y–Prospective Day Care employee *(fee required - see below)* *<br>–Applying to be a Group Family Day Care Assistant. (fee required - see below) *<br>Prospective employee of legally-exempt family child care (fee required-see below)* |

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).

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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**

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, <u>all</u> 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 M/F | DATE OF BIRTH mm | dd | yyyy |
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Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

▶ Go to *www.irs.gov/FormW9* for instructions and the latest information.

**Give Form to the requester. Do not send to the IRS.**

Print or type. See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ▶ ________

**Note:** Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) ________

Exemption from FATCA reporting code (if any) ________

*(Applies to accounts maintained outside the U.S.)*

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

**Note:** If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

**Social security number**

☐☐☐ – ☐☐ – ☐☐☐☐

**or**

**Employer identification number**

☐☐ – ☐☐☐☐☐☐☐

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

**Certification instructions.** You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

**Sign Here** **Signature of U.S. person ▶** **Date ▶**

# General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

**Future developments.** For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

## Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

*If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See* What is backup withholding, *later.*

# DELAWARE OPPORTUNITIES INC.

35430 STATE HIGHWAY 10, HAMDEN, NY 13782

PHONE (607) 746-1600 • FAX (607) 746-1605
email: delopp@delawareopportunities.org
website: www.delawareopportunities.org

SERVING
DELAWARE COUNTY

HEAD START
RESPITE CARE
SERVICES COORDINATION
BIG BUDDY
PARENT AIDE
DAY CARE
RESOURCE/REFERRAL
(Registration)
(Subsidies)
(USDA Sponsor)
(Inspections)
HEALTHY FAMILIES
PREGNANT AND PARENTING TEENS

SENIOR DINING

SAFE AGAINST VIOLENCE
(Domestic Violence)
(Rape Crisis)
(Crime Victims)

JOBS WORK CREW
JOB COACHES

EMPLOYMENT AND TRAINING

COMMUNITY FOOD AND NUTRITION

WEATHERIZATION

HOUSING ASSISTANCE AND
COMMUNITY DEVELOPMENT
(Housing Development)
(Homeownership/Tenant Counseling)
(Rental Assistance)
(Housing Rehabilitation)

HEAP

FAMILY DEVELOPMENT

FAMILY RESIDENCES
INDEPENDENT LIVING SKILLS

WIC
(Women, Infants and Children)
(Car Seat Safety)

NEIGHBORHOOD CENTER
CLOTHING/HOUSEHOLD GOODS/
AND FOOD BANK SERVICES

EMERGENCY FOOD
AND SHELTER

HOMELESS ASSISTANCE

TRANSPORTATION

Dear Provider:

There will be a change in the processing and structure of the day care subsidy vouchers. We are asking providers to participate in the new system called child care time and attendance. (CCTA). Enclosed is the information regarding the CCTA system and how it will work? **If a provider chooses not to participate in the CCTA system, Providers are still required to provide their rates**. Enclosed is a form that needs to be completed and returned. If you choose to participate in the CCTA system, provider also must fill out the agreement form and have the form notarized. All information must be returned Delaware Opportunities in order to process any payments. Please call if you have questions (607) 746-1620.

Providers Name: _______________

Providers Address: ____________

I will participate: __________ in the CCTA system.

I will not participate: ___________ in the CCTA system.

Sincerely:

Judy Velten
CFD Coordinator

Cc: J. Eberhard,
J. Montgomery

*"Helping people become self-sufficient and attain a better quality of life." since 1965*

CCFS#: ____________________

Provider Name: ____________________

Address: ____________________

____________________

Date of Birth: ____________________

Contact Name: ____________________

Phone # ____________________

If you operate with specific hours please indicate them here (example M-F 6 am to 7 pm)

____________________

| Rate/Age | Under 1 ½ years | 1 ½ to 2 years | 3 to 5 years | 6 to 12 years |
|---|---|---|---|---|
| **Weekly Rate** *Care provided for 30 or more hours over the course of 5 or fewer days in a week.* | | | | |
| **Daily Rate** *Care is provided for at least 6 but fewer than 12 hours per day* | | | | |
| **Part Day Rate** *Care is provided for at least 3 but less than 6 hours per day* | | | | |
| **Hourly Rate** *Care is provided for less than 3 hours per day* | | | | |

DELAWARE OPPORTUNITIES/ DELAWARE COUNTY

35430 STATE HIGHWAY 10, HAMDEN, NY 13782

## CHILD CARE TIME AND ATTENDANCE USER AGREEMENT

The Provider would like to commence using the New York State Office of Children and Family Services, Child Care Time and Attendance (NYS OCFS CCTA) electronic filing system to submit time records for child care services to Delaware Opportunities Inc, Delaware County Department of Social Services electronically.

Upon execution of this agreement, the Provider will electronically submit all claims for payment and all required child attendance information to the County through the use of the NYS OCFS CCTA system.

The Provider acknowledges that they are solely responsible for the information submitted to the County electronically through the NYS OCFS CCTA system pursuant to the provisions of Section 415 of the State of New York Codes, Rules and Regulations and Section ____ of the County Law of the State of New York. The Provider affirms that such information will be complete and accurate. The Provider understands and agrees that the County will hold the Provider responsible for any false, incomplete or misleading information submitted to the County by the Provider or under the Provider's name.

The Provider further understands and acknowledges that he/she could be prosecuted under applicable Federal and State laws for any false claims, statements, documents, or payment submitted to the County.

The Provider acknowledges and agrees that any information submitted to the County by the Provider's or on the Provider's behalf will be treated as if the Provider has personally signed the sheets upon which the information is contained and that the Provider will be held to the same standard as if the submissions were made in written form as opposed to electronic form.

The County reserves the right to rescind this agreement and the Provider's use and access to the NYS OCFS CCTA system. This agreement may be rescinded at any time effective the beginning of the month following the County's notice to the Provider. The Provider may terminate this agreement and their use of NYS OCFS CCTA system upon providing the County with at least thirty (30) days written notice. Such termination to be effective the beginning of the month following the thirty (30) day written notice. This agreement shall remain in full force and effect until terminated pursuant to this paragraph.

Provider Name: ________________________________

Provider Number: ________________________________

Provider Address: ________________________________

________________________________

Signature: ________________________________

Date: ________________________________

Print Name: ________________________________

Acknowledged and affirmed to before me
appeared ____________ on this ____day
of ____________, 2014.

________________________________

Notary Public

# DELAWARE OPPORTUNITIES INC.

35430 STATE HIGHWAY 10, HAMDEN, NY 13782

PHONE (607) 746-1600 • FAX (607) 746-1605
email: delopp@delawareopportunities.org
website: www.delawareopportunities.org

Dear Provider:

We are proud to announce that we will be using an automated system called Child Care Time and Attendance (CCTA) to improve the accuracy and timeliness of New York State's child care subsidy payments. This new time and attendance system will begin operation in **Delaware County on April 1, 2011.** To participate in this exciting new opportunity, and be the first to start using the new CCTA system, contact **Delaware Opportunities, Judy Velten or Lisa Calaci at (607) 746-1620.**

**What are the main benefits of having a statewide CCTA system?**

- Simplify time and attendance workload;
- Save money on postage operating costs; and
- Improve timeliness and accuracy of payments to child care providers.

**What will CCTA do?**

- Verify if providers are eligible to receive payment for subsidized child care;
- Track the time and attendance of children;
- Calculate and authorize child care payments;
- Allow parents and other caretakers to check their children in and out of a child care program using the provider's computer which will be connected to the new system through a Web-based time clock; and
- Allow providers to see when children in their care lose their eligibility to receive subsidy.

**What equipment is needed to use CCTA?**
With CCTA there is no software for you to purchase. The only item required is a **desktop or notebook computer that can access the Internet** by using any of the following web browsers: Internet Explorer (IE); Firefox, Chrome or Safari.

**How do you use CCTA?**
You use the Internet to access CCTA to record and submit your attendance for children receiving a child care subsidy. If you don't have a computer with Internet access, you can use your local library's computer or any other computer with Internet access, to record your time and attendance records. In addition, if you choose the time clock option, parents or other caretakers use your computer to access CCTA and check their children in and out of your day care. This saves you from typing in the attendance for each child. Access and passwords and provided.

**How do you learn how to use CCTA?**
Online training is available to teach you how to use CCTA. There is also a call center for assistance.

**What do you need to do before you start to use CCTA?**
Getting started is easy. Let us know that you want to use CCTA and we provide your access. The only requirement is to fill out the provider rate form with your child care hours and rate. We are looking forward to working with our providers using this new and efficient automated time and attendance system. Welcome aboard, we're glad you joined us!