REVISED
2:53 pm, Jan 18, 2022

A-Series (Oct 2021)

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REQUIRED FORMS AND CLEARANCE LIST

GROUP CHILD CARE PROGRAMS

The following forms listed must be completed for all staff and volunteers:

- **Group Child Care Program Staff and Volunteers:** The Education 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 NYS OCFS*. Your clearances will **NOT** be processed without payment. Make an appointment with IdentoGo or DOE PETS for fingerprinting. Keep all receipts and submit all clearance documents to your program Director. Applications submitted without proof of fingerprinting will be considered incomplete and rejected. A complete A-Series must be submitted to the DOHMH Central Clearance Unit (CCU) via Fax: 347-396-8052 or email: A-BSeries@health.nyc.gov. When emailing submissions, please **submit one email per employee** and be sure to format the subject line as follows: [A-Series] [Child Care Program Name], [DCID #], [Employee First Name] [Employee Last Name]. Warning: *private information sent via email may not be secure depending on your email or other security settings*
- **Group Child Care Education Directors:** Submit all required forms listed below to your borough office. SCR payment must go to OCFS*. Your clearances will **NOT** be processed without payment. Make an appointment with IdentoGo or DOE PETS for fingerprinting. Applications submitted without proof of fingerprinting will be considered incomplete and rejected.

Application Item	REQUIRED for All Staff & Volunteers Group Child Care programs
LDSS-3370 *Statewide Central Register Database Check (includes the form and instructions for completing the DCCS version)* ***NOTE: please insert your program's* Permit # & DCID in place of the CCFS #**	X
A1 *Child Care Provider, Staff and Volunteer Information*	X
A2 *Request for Staff Exclusion List Check*	X
A3 *Waiver Request for Comprehensive Background Clearance*	
IdentoGo/PETS Fingerprint *Request for Fingerprinting—Receipt Must be Retained and Submitted*	X

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

New York State Criminal History Record Check (IdentoGo/PETS Fingerprint) *NYS Department of Criminal Justice Services*
National Criminal Record Check (IdentoGo/PETS Fingerprint) *Federal Bureau of Investigation*
New York State Sex Offender Registry Search (form A1) *NYS Department of Criminal Justice Services*
****National Sex Offender Registry Search (IdentoGo/PETS Fingerprint)** *National Crime and Information Center*
Statewide Central Register Database Check (form LDSS-3370) *SCR of Child Abuse and Maltreatment*
Staff Exclusion List Check (form A2) *New York State Justice Center*
State Sex Offender Registry, Child Abuse or Maltreatment, and Criminal History Repository Search (form A1) *In each state other than New York where you have lived in the last 5 years*

*** NYS Office of Children and Family Services Bureau of Financial Operations**
52 Washington Street, Rm 204S Rensselaer, NY 12144 Rensselaer, NY 12144

****Required in accordance with a schedule that will be released by the office at a later date**

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Child Care Provider, Staff and Volunteer Information

GROUP CHILD CARE PROGRAMS

Instructions:

- Please **PRINT** clearly. This form **MUST** be completed by every individual identified on form **A-Series**.
- If you are not sure which role to choose, refer to the NYCHC §47 regulations and/or consult with your Borough Office.

PROGRAM NAME:	Permit # & DCID:
DATE:	

Group Child Care Staff Role	
☐ Education Director	☐ Owner
☐ Group Teacher	☐ Board Member
☐ Assistant Teacher	☐ Medical Staff
☐ Volunteer/Student	☐ Other _____

Personal Information

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

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

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

_____

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

If Yes, complete page 2 of this form and enter all out of state addresses where you lived in the past five years.

If No, you do not have to complete page 2.

Type of Fingerprint completed after 9/25/2019? ☐ IdentoGo ☐ DOE

Note: Clearances are incomplete if fingerprints were completed prior to 9/25/2019 or if completed by another agent other than Idemia through IdentoGo or Department of Education (DOE) PETS.

Signature _____ **Date** _____

Applicant's Name: ____

Out of state addresses (Previous five years)

Print clearly. <u>All</u> dates must be consecutive *(month/year)*. Be sure to associate address histories accurately.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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Signature ____ **Date** ____

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

REQUEST FOR STAFF EXCLUSION LIST CHECK

GROUP CHILD CARE PROGRAMS

PROGRAM NAME:	Permit # & DCID:

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 **A-Series** form.

Instructions:

- This form is used to check the Justice Center's (SEL).
- Group Child Care Programs must submit the SEL for DOHMH.

  Note: 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:

Signature _____ **Date** _____

NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

WAIVER REQUEST TO ASSOCIATE OR TRANSFER COMPREHENSIVE BACKGROUND CHECK CLEARANCE

Instructions:

Complete this request to associate an individual's existing and active comprehensive background check (CBC) with an additional permitted child care provider. All fields are required unless otherwise noted. Incomplete applications will not be processed. Unless submitted with an initial CBC application, a new SCR and A-2 application will be required. Completed forms must be submitted to the DOHMH Central Clearance Unit (CCU) via Fax: 347-396-8052 or email: A-BSeries@health.nyc.gov. When emailing submissions, please be sure to format the subject line as follows: [A-3 Waiver], [Employee First Name] [Employee Last Name]. Warning: *private information sent via email may not be secure depending on your email or other security settings*

Staff/Volunteer Information

Staff/Volunteer First & Last Name: _____ DOE PETS# (if applicable): _____

Date of Birth: _____ Social Security Number: _____

Date of Clearance: _____ Staff/Volunteer Signature: _____ Date: _____

Original Program Associated with Comprehensive Background Check

Program Name: _____

Program Address: _____

Borough_____ Zip Code_____ Permit/DC ID#_____

☐ I remain active at the above site ☐ I am no longer associated with the above site as of _____
DATE

New Program Information

Program Name: _____ Permit/DC ID#_____

Program Address: _____ Borough Staten Island Zip Code_____

Start Date at the New site: _____ Position Title at New Site: _____

Program Name: _____ Permit/DC ID#_____

Program Address: _____ Borough Staten Island Zip Code_____

Start Date at the New site: _____ Position Title at New Site: _____

ADDITIONAL PAGE

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island ____________ Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island ____________ Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island ____________ Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island ____________ Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island ____________ Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

Program Name: ______________________________ Permit/DC ID#____________________

Program Address: ______________________ Borough Staten Island Zip Code______________

Start Date at the New site: ______________ Position Title at New Site: ____________________

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/Non-Binary column: check either M (Male) or F (Female) or Non-Binary 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.**

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

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STATEWIDE CENTRAL REGISTER DATABASE CHECK

Agency Use Only

SCR USE ONLY
REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

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

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

AGENCY NAME:

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
APPLICANT			☐ M ☐ F	
APPLICANT MAIDEN/ALIAS/ MARRIED NAME			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

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

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

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

APPLICANT'S SIGNATURE	DATE / /

APPLICANT'S SIGNATURE	DATE / /

EIGHTEEN-YEARS OF AGE OR OLDER:

I understand that as a person 18 years of age or older in a home of an applicant to become an Adoptive or a Foster Parent or a Family or Group Family Day Care provider, the information I have provided will be used to inquire of the Statewide Central Register to determine if I am the subject of an indicated report of child abuse or maltreatment.

SIGNATURE	DATE / /

SIGNATURE	DATE / /

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	**N**- Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*
D- Prospective employee *(Local DSS district - bill against reimbursement)***	**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.*
E- Current employee	**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.*
F- Prospective/new employee other than day care employees. (fee required - see below)*	**R**- Applying to be kinship foster parents.
G-This is a provider, employee, volunteer, or household member 18 years of age or older not related to any child in care, 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)	**S**- Provider of goods/services
	U- Universal Pre-K Teacher *(fee required - see below)**
	W- Applying to be foster parents or family care home providers.
I- This is a provider, employee, or volunteer at a legally-exempt in-home care. 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)	**X**- Applying to be adoptive parents pursuant to an application pending before the inquiring agency.
	Y- Prospective Day Care employee *(fee required - see below)** - Applying to be a Group Family Day Care Assistant. (Fee required - See below)*
J- Age 18 or Older Household Member (with no child care role)	
L- This is a director, employee, or volunteer at legally exempt group child care. (this category is only to be used by Enrollment Agencies).	**Z**- Prospective volunteer/consultant.
M- Director of a summer camp, overnight camp, day camp or traveling day camp.	

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 requires the collection of a **$25.00 fee** for certain categories. A certified check, postal or bank money order, teller's check, cashier's check or agency check made payable to *"New York State Office of Children and Family Services"* in the amount of twenty-five dollars, is to accompany the form. The check 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**
BE SURE TO INCLUDE THE REQUIRED FEE – **FEE REQUIRED FOR EACH APPLICANT**

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

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

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

APPLICANT NAME: _____

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

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

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM

ADDITIONAL PAGE

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

APPLICANT NAME: _____

Other Household Members are: (please print clearly):

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

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