INSTRUCTIONS TO COMPLETE EMPLOYMENT APPLICATION.

- **Cover Sheet**:

Mark off what position you're applying for, as well as the client's name with whom you will be working. The bottom box is a checklist for your convenience to ensure that everything is Completed.

- **Employment Application**:

Complete this general application, sign and date.

- **Principles of Conduct**:

Read, sign and date.

- **Code of Conduct**:

Read through all three pages; sign & print your name and date. Enter the name of the program and department you'll be working for, as well as the name of the organization (Rayim)

- **Physical Examination**:

To be completed by a physician or you may forward a copy of a recent annual physical exam from your doctor.

- **Hepatitis B Form**:

Choose to mark off one of the four choices that best suits you. You may mark of the 2nd option (I decline…) sign, and date.

- **I-9 employee section**:

Complete all information. A form of ID is required as a part of this document. See list of acceptable documents (2 forms following I-9). E.G. a copy of current passport, a copy of driver's license AND Social Security Card.
Employer section should be left empty; it is to be completed by Rayim.

- **Statewide Central Register Database Check**:

Complete lower part – List all your household members (such as husband and children). List your information and where you lived since 1972.

- **Statement of Provisional Employees**:

This form is necessary to be completed on a monthly basis, in the event that your fingerprinting process isn't completed before your start date of employment.

- **Form W-4**:

Complete basic information and sign. Make sure to enter the amount of allowances at blank 5.

- **Arranging appointment for Finger Printing**:

Follow instructions from the attached 'CBC Finger Printing Process Instruction Sheet'.

- **Forms titled NYS Justice Center**:

Complete the four forms from the NYS Justice Center and take along to your fingerprinting appointment. A fingerprinting appointment will be rejected if you fail to present those forms.

- **High School Diploma or Equivalent**:

Please provide proof of education (High School/Yeshiva).

* All Com Hab, Day Hab and Respite employees are Regular W-2 employees, which mean that taxes are being deducted from every check.

Good Luck!

EMPLOYMENT APPLICATION

NAME OF APPLICANT:	
NAME OF CONSUMER:	

POSITION APPLYING

☐	Administration	☐	Medicaid Service Coordination
☐	Article 16 Clinic	☐	Day Habilitation
☐	Individual Residential Alternative	☐	Supportive Employment
☐	Home Family Care	☐	Direct Care Worker

CHECKLIST

☐	Employment Application	☐	Form W-4
☐	Principles of Conduct	☐	NYS Justice Center #1
☐	Codes of Conduct	☐	NYS Justice Center #2
☐	Physical Examination	☐	NYS Justice Center #3
☐	Hepatitis B Vaccination Status Form	☐	NYS Justice Center #4
☐	Employment Eligibility Verification (Form I-9)	☐	Passport/Driver's License & Social security Card
☐	State Central Register Database Check	☐	Diplomas

EMPLOYMENT APPLICATION

NAME:		
ADDRESS:		
CITY, STATE, ZIP:	TELEPHONE # INCLUDING AREA CODE:	
CELL PHONE # INCLUDING AREA CODE:	MAIDEN NAME OR MOTHERS MAIDEN NAME:	
DATE OF BIRTH:	SOCIAL SECURITY #:	
EMPLOYMENT DESIRED:	PLEASE NAME IF RELATED TO ANYONE IN OUR AGENCY:	
EDUCATION HISTORY OR ATTACH RESUME:		
HAVE YOU EVER BEEN CONVICTED OF A CRIME:	DO YOU DRIVE:	DRIVERS LICENSE #:
IF YES, PLEASE INDICATE IF WITHIN THE LAST THREE YEARS YOU HAD ANY [ ] MOVING VIOLATION [ ] SUSPENSION [ ] REVOCATION [ ] DWI [ ] CONVICTIONS [ ] ANY OCCURANCE INVOLVING PERSONS OR PROPERTY WHILE DRIVING.		
LAST EMPLOYMENT HISTORY (INCLUDE DATES):		
LIST NAMES, ADDRESS AND PHONE OF 3 REFERENCES:		
I AUTHORIZE INVESTIGATION OF ALL STATEMENTS CONTAINED IN THIS APPLICATION. I UNDERSTAND THAT MISREPRESENTATION OR OMMISSION OF FACTS CALLES FOR ITS CAUSE FOR DISMISSAL. FURTHER I UNDERSTAND AND AGREE THAT MY EMPLOYMENT IS NOT FOR A DEFINITIVE PERIOD AND MAY, REGARDLESS OF THE DAT OF PAYMENT OF MY WAGES AND SALARY BE TERMINATED AT ANY TIME WITHOUT PREVIOUS NOTICE. ADDITIONALLY, I THE UNDERSIGNED HEREBY AFFIRM THAT ALL STATEMENTS MADE BY ME IN THIS APPLICATION ARE COMPLETELY TRUE.		
I THE UNDERSIGNED, HEREBY AFFIRM THAT I HAVE NEVER BEEN CHARGED OR CONVICTED OF ANY CRIMINAL CHARGES.		
SIGNATURE:		
DATE:		
IF HIRED, EMPLOYEE WILL COMPLETE THE FOLLOWING: PRINCIPLES OF CONDUCT, EMPLOYEE INTERVIEW SUMMARY, EMPLOYEE PHYSICAL, VERIFICATION OF PPD TEST, HEPATITIES B VACCINATION STATUS FORM, FORM 1-9, W-4 FORM, ABUSE REGISTRY FORM AND SUBMIT COPIES OF DRIVERS LICENSE AND SOCIAL SECURITY CARDS. EMPLOYEES MUST ALSO COMPLETE ALL MANDATORY TRAINING OFFERED BY RAYIM AS REQUIRED BY OMRDD.		

PRINCIPLES OF CONDUCT

1. THERE SHOULD BE NO USE OF CORPORAL PUNISHMENT UPON CLIENTS.
2. EMPLOYEES SHOULD NOT ENGAGE IN ANY ACTIVITY THAT CONSTITUTES ABUSE OF CLIENTS AS DEFINED IN THE REGULATIONS OF THE COMMISSIONER.
3. EMPLOYEES SHOULD NOT MODEL INAPPROPRIATE OR UNACCEPTABLE BEHAVIOR TO A CLIENT.
4. EMPLOYEES SHOULD TREAT CLIENT'S INFORMATION AS CONFIDENTIAL AND UTILIZE SUCH INFORMATION IN A PROFESSIONAL MANNER AT ALL TIMES.
5. THERE SHOULD BE NO DISCRIMINATORY ACTIVITY AGAINST CLIENTS OR OTHERS FOR ANY REASON, INCLUDING RACE, NATIONAL ORIGIN, CREED, AGE, SEX, ETHNIC BACKGROUND, DEVELOPMENTAL DISABILITY OR OTHER HANDICAP.
6. EMPLOYEES SHOULD NOT DISTRIBUTE, SELL, POSSESS, PURCHASE OR CONSUME ILLEGAL SUBSTANCE OR ALCOHOL WHILE AT THE WORK PLACE OR WHILE PERFORMING IN A WORK RELATED CAPACITY.
7. EMPLOYEES SHOULD NOT WORK IF THEIR ABILITY TO PERFORM THEIR JOB IS IMPAIRED TO THE USE OF ALCOHOL, AND A CONTROLLED SUBSTANCE, AN ILLEGAL SUBSTANCE, OR PRESCRIBED MEDICATION.
8. CLIENTS SHOULD NOT CARRY OUT THE DUTIES OF PROVIDERS UNLESS SUCH TASKS ARE DESCRIBED IN THE CLIENT'S PLAN OF SERVICES BY THE CLIENTS PROGRAM PLANNING TEAM FOR THE PURPOSE OF INCREASING THE CLIENT'S SKILLS.
9. CLIENTS SHOULD NOT BE SUBJECTED TO INAPPROPRIATE FIREARMS OR OTHER WEAPONS IN OR ON THE GROUNDS OF THE CLIENT'S RESIDENCE.
10. THERE SHOULD BE NO FINANCIAL TRANSACTION BETWEEN PROVIDERS AND CLIENTS, WHICH MAY CONSTRUE AS CLIENT EXPLOITATION OR RESULT IN GREATER BENEFIT TO PROVIDER, THAN THE CLIENT.

I HAVE READ THE PRINCIPLES OF CONDUCT FOR WORKING IN THIS PROGRAM AND UNDERSTAND THAT A FAILURE TO COMPLY WITH THESE PRINCIPLES MAY CAUSE FOR IMMEDIATE SUSPENSION OF MY EMPLOYMENT

SIGNATURE		DATE:	

CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

June 10, 2013

Introduction

The Protection of People with Special Needs Act ("the Act") establishes the Justice Center for the Protection of People with Special Needs ("Justice Center") and requires that this Code of Conduct be read and signed by anyone who will have regular and substantial contact with any person who is receiving services or supports from facilities or providers covered by the Act.

The Code of Conduct is not intended to provide a detailed list of what to do in every aspect of your work. Instead it represents a framework that will help custodians determine how to help people with special needs live self-directed, meaningful lives in their communities, free from abuse and neglect, and protected from harm.

You must abide by the following Code of Conduct provisions:

1. **Person-Centered Approach**

   My primary duty is to the people who receive supports and services from this organization. I acknowledge that each person of suitable age must have the opportunity to direct his or her own life, honoring, where appropriate, their right to assume risk in a safe manner, and recognizing each person's potential for lifelong learning and growth. I understand that my job will require flexibility, creativity and commitment. Whenever appropriate, I will work to support the individual's preferences and interests.

2. **Physical, Emotional and Personal Well-being**

   I will promote the physical, emotional and personal well-being of any person who receives services and supports from this organization, including their protection from abuse and neglect and reducing their risk of harm. I will immediately report any situation in which any person receiving services or supports is experiencing, or is at risk of experiencing abuse or neglect.

3. **Respect, Dignity and Choice**

   I will respect the dignity and individuality of any person who receives services and supports from this organization and honor their choices and preferences whenever possible and appropriate. I will help people receiving supports and services use the opportunities and resources available to all in the community, whenever possible and appropriate.

4. **Self-Determination**

   I will help people receiving supports and services realize their rights and responsibilities, and, as appropriate, make informed decisions and understand their options related to their physical health and emotional well-being.

5. **Relationships**

I will help people who receive services and supports from this organization maintain or develop healthy relationships with family and friends. I will support them in making informed choices about safely expressing their sexuality and other preferences, whenever possible and appropriate.

6. **Advocacy**

I will advocate for justice, inclusion and community participation with, or on behalf of, any person who receives services and supports from this organization, as appropriate. I will promote justice, fairness and equality, and respect their human, civil and legal rights.

7. **Personal Health Information and Confidentiality**

I understand that persons served by my organization have the right to privacy and confidentiality with respect to their personal health information and I will protect this information from unauthorized use or disclosure, except as required or permitted by law.

8. **Non-Discrimination**

I will not discriminate against people receiving services and supports or colleagues based on race, religion, national origin, sex, age, sexual orientation, economic condition or disability.

9. **Integrity, Responsibility and Professional Competency**

I will reinforce the values of this organization when it does not compromise the well-being of any person who receives services and supports. I will maintain my skills and competency through continued learning, including all training provided by this organization. I will actively seek advice and guidance of others whenever I am uncertain about an appropriate course of action. I will not misrepresent my professional qualifications or affiliations. I will demonstrate model behavior to all, including persons receiving services and supports.

10. **Reporting Requirement**

As a mandated reporter, I acknowledge my legal obligation to report all allegations of reportable incidents immediately upon discovery to the Justice Center's Vulnerable Persons' Central Register by calling 1-855-373-2122.

PLEDGE TO ABIDE BY THE CODE OF CONDUCT FOR CUSTODIANS OF PEOPLE WITH SPECIAL NEEDS

I pledge to prevent abuse, neglect, or harm toward any person with special needs. If I learn of, or witness, any incident of abuse, neglect or harm toward any person with special needs, I will offer immediate assistance and then notify emergency personnel, including 9-1-1 where appropriate, and inform the management of this organization. I pledge also to report the incident to the Justice Center for the Protection of People with Special Needs.

I acknowledge that I have read and that I understand the Code of Conduct.

I agree to abide by this Code of Conduct.

______________________	________________	___________
Signature	Print Name	Date

Program:

Department:

Facility/Provider Organization:

EMPLOYEE PHYSICAL EXAMINATION

NAME		SOCIAL SECURITY #	
FACILITY	DATE	POSITION APPLIED FOR	
MEDICAL HISTORY (including epilepsy, mental illness, hypertension, diabetes series operation, accidents or illnesses, alcoholism)			
IMMUNIZATION HISTORY:			
HT	WT	TEMP	B/P
SKIN:		NOSE	
THROAT AND NECK (Thyroid, lymph, nodes, flexibility)			
ORAL AND DENTAL HYGIENE			
THORAX AND LUNGS			
CARDIOVASCULAR			
EXERCISE TOLERANCE			
PULSE AT REST			
AFTER EXERCISE			
ABDOMEN (Hernias, Organs, Masses)			
GENITAL - URINARY (optional)			
EXTREMITIES			
MUSCULAR SKELETAL			
NEUROLOGICAL			
VISION WITHOUT GLASSES			
VISION WITH GLASSES			
HEARING			
S/S OF COMMUNICABLE DISEASE			
DOES CANDIDATE MEET MEDICAL REQUIREMENT TO WORK?			
DOCTORS SIGNATURE		DATE	

HEPATITIS B VACCINATION STATUS FORM

NAME:	
DATE OF BIRTH:	
SOCIAL SECURITY NUMBER:	
FACILITY:	
POSITION:	

THIS FORM IS TO BE SIGNED BY ALL COVERED INDIVIDUALS WHO ARE AT RISK FOR OCCUPATIONAL EXPOSURE TO BLOOD OR POTENTIALLY INFECTIOUS MATERIALS.

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine, at no charge to myself.

[ ]	I request immunization. The first vaccination to be administrated on ________/________/________.
[ ]	I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.
[ ]	I decline Hepatitis B vaccination at this time because I have previously completed the vaccination series on _______/_______/_______.
[ ]	THIS POSITION IS NOT A POSITION DETERMINED TO BE AT RISK OF EXPOSURE.

INDIVIDUAL:	DATE:
DIRECTOR:	DATE:

Employment Eligibility Verification

Department of Homeland Security

U.S. Citizenship and Immigration Services

USCIS
Form I-9
OMB No. 1615-0047
Expires 08/31/2019

►**START HERE: Read instructions carefully before completing this form. The instructions must be available, either in paper or electronically, during completion of this form. Employers are liable for errors in the completion of this form.**

ANTI-DISCRIMINATION NOTICE: It is illegal to discriminate against work-authorized individuals. Employers **CANNOT** specify which document(s) an employee may present to establish employment authorization and identity. The refusal to hire or continue to employ an individual because the documentation presented has a future expiration date may also constitute illegal discrimination.

Section 1. Employee Information and Attestation *(Employees must complete and sign Section 1 of Form I-9 no later than the **first day of employment**, but not before accepting a job offer.)*

Last Name *(Family Name)*	First Name *(Given Name)*	Middle Initial	Other Last Names Used *(if any)*

Address *(Street Number and Name)*	Apt. Number	City or Town	State	ZIP Code

Date of Birth *(mm/dd/yyyy)*	U.S. Social Security Number	Employee's E-mail Address	Employee's Telephone Number
	☐☐☐ - ☐☐ - ☐☐☐☐		

I am aware that federal law provides for imprisonment and/or fines for false statements or use of false documents in connection with the completion of this form.

I attest, under penalty of perjury, that I am (check one of the following boxes):

☐ 1. A citizen of the United States

☐ 2. A noncitizen national of the United States *(See instructions)*

☐ 3. A lawful permanent resident (Alien Registration Number/USCIS Number): ____________

☐ 4. An alien authorized to work until (expiration date, if applicable, mm/dd/yyyy): ____________
Some aliens may write "N/A" in the expiration date field. *(See instructions)*

Aliens authorized to work must provide only one of the following document numbers to complete Form I-9:
An Alien Registration Number/USCIS Number OR Form I-94 Admission Number OR Foreign Passport Number.

1. Alien Registration Number/USCIS Number: ____________

OR

2. Form I-94 Admission Number: ____________

OR

3. Foreign Passport Number: ____________

Country of Issuance: ____________

QR Code - Section 1
Do Not Write In This Space

Signature of Employee	Today's Date *(mm/dd/yyyy)*

Preparer and/or Translator Certification (check one):

☐ I did not use a preparer or translator. ☐ A preparer(s) and/or translator(s) assisted the employee in completing Section 1.

(Fields below must be completed and signed when preparers and/or translators assist an employee in completing Section 1.)

I attest, under penalty of perjury, that I have assisted in the completion of Section 1 of this form and that to the best of my knowledge the information is true and correct.

Signature of Preparer or Translator	Today's Date *(mm/dd/yyyy)*

Last Name *(Family Name)*	First Name *(Given Name)*

Address *(Street Number and Name)*	City or Town	State	ZIP Code

Employer Completes Next Page

LISTS OF ACCEPTABLE DOCUMENTS
All documents must be UNEXPIRED

Employees may present one selection from List A
or a combination of one selection from List B and one selection from List C.

LIST A **Documents that Establish Both Identity and Employment Authorization**	OR	LIST B **Documents that Establish Identity**	AND	LIST C **Documents that Establish Employment Authorization**
1. U.S. Passport or U.S. Passport Card **2.** Permanent Resident Card or Alien Registration Receipt Card (Form I-551)		**1.** Driver's license or ID card issued by a State or outlying possession of the United States provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**1.** A Social Security Account Number card, unless the card includes one of the following restrictions: (1) NOT VALID FOR EMPLOYMENT (2) VALID FOR WORK ONLY WITH INS AUTHORIZATION (3) VALID FOR WORK ONLY WITH DHS AUTHORIZATION
3. Foreign passport that contains a temporary I-551 stamp or temporary I-551 printed notation on a machine-readable immigrant visa		**2.** ID card issued by federal, state or local government agencies or entities, provided it contains a photograph or information such as name, date of birth, gender, height, eye color, and address		**2.** Certification of Birth Abroad issued by the Department of State (Form FS-545)
4. Employment Authorization Document that contains a photograph (Form I-766)		**3.** School ID card with a photograph **4.** Voter's registration card		**3.** Certification of Report of Birth issued by the Department of State (Form DS-1350)
5. For a nonimmigrant alien authorized to work for a specific employer because of his or her status: **a.** Foreign passport; and **b.** Form I-94 or Form I-94A that has the following: (1) The same name as the passport; and (2) An endorsement of the alien's nonimmigrant status as long as that period of endorsement has not yet expired and the proposed employment is not in conflict with any restrictions or limitations identified on the form.		**5.** U.S. Military card or draft record **6.** Military dependent's ID card **7.** U.S. Coast Guard Merchant Mariner Card **8.** Native American tribal document **9.** Driver's license issued by a Canadian government authority **For persons under age 18 who are unable to present a document listed above:**		**4.** Original or certified copy of birth certificate issued by a State, county, municipal authority, or territory of the United States bearing an official seal **5.** Native American tribal document **6.** U.S. Citizen ID Card (Form I-197) **7.** Identification Card for Use of Resident Citizen in the United States (Form I-179)
6. Passport from the Federated States of Micronesia (FSM) or the Republic of the Marshall Islands (RMI) with Form I-94 or Form I-94A indicating nonimmigrant admission under the Compact of Free Association Between the United States and the FSM or RMI		**10.** School record or report card **11.** Clinic, doctor, or hospital record **12.** Day-care or nursery school record		**8.** Employment authorization document issued by the Department of Homeland Security

Examples of many of these documents appear in Part 8 of the Handbook for Employers (M-274).

Refer to the instructions for more information about acceptable receipts.

Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: Must include street, city

APPLICANT INFORMATION

APPLICANT/HOUSEHOLD MEMBER AREA:

- **ALL** HOUSEHOLD MEMBERS, ADULTS AND CHILDREN, WHETHER RELATED TO THE APPLICANT OR NOT, ARE TO BE LISTED IN THIS AREA OF THE FORM.
- Remember to **write clearly** or **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach an additional page if needed.)

If there are no other household members, indicate NONE on the line below "Maiden/Alias".

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

ADDRESS AREA:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older. We need this information for the last 28 years. Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals (i.e., indicate which addresses are for which household members).
- For all other categories, only the applicant's address history is required – for the last 28 years.
- Complete addresses are required. Include street name and city/town/village. Also include street number and apartment number. **Post Office Box numbers are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for category), signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- All signatures must correspond to the names recorded in the Applicant/Household Member Area-for example; Mary Smith should not sign Mary Ann Smith. Victoria Smith should not sign Vicki.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated (mm/dd/yy). The SCR **will not accept** a form with a signature date more than 6 months old.

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

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://www.ocfs.state.ny.us/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to: **THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.**

LDSS-3370 (Rev. 04/2011) 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 CODE:	PHONE NUMBER **(Area Code):**
				( ) -

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

AGENCY NAME:

AGENCY LIAISON:

STREET ADDRESS

CITY: **STATE:** **ZIP CODE:**

The particular classifications of persons who must or may be screened are set forth on the reverse side of this document. The alpha codes to complete the "Category" box above are also on the reverse side of this form

FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your children and any other person(s) in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME/ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE" *List RELATIONSHIP in the fields below*

(see reverse side for instructions) Attach additional page if necessary.

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

APPLICANT/HOUSEHOLD MEMBER AREA *PLEASE TYPE OR PRINT CLEARLY

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

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

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

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

APPLICANT'S SIGNATURE	DATE	APPLICANT'S SIGNATURE	DATE

EIGHTEEN YEARS OLD OR OVER:

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

SIGNATURE	DATE	SIGNATURE	DATE

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ______________________________

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: ______________________________

Other Household Members are (please print clearly):

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

Form W-4 (2017)

Purpose. Complete Form W-4 so that your employer can withhold the correct federal income tax from your pay. Consider completing a new Form W-4 each year and when your personal or financial situation changes.

Exemption from withholding. If you are exempt, complete **only** lines 1, 2, 3, 4, and 7 and sign the form to validate it. Your exemption for 2017 expires February 15, 2018. See Pub. 505, Tax Withholding and Estimated Tax.

Note: If another person can claim you as a dependent on his or her tax return, you can't claim exemption from withholding if your total income exceeds $1,050 and includes more than $350 of unearned income (for example, interest and dividends).

Exceptions. An employee may be able to claim exemption from withholding even if the employee is a dependent, if the employee:

- Is age 65 or older,
- Is blind, or
- Will claim adjustments to income; tax credits; or itemized deductions, on his or her tax return.

The exceptions don't apply to supplemental wages greater than $1,000,000.

Basic instructions. If you aren't exempt, complete the **Personal Allowances Worksheet** below. The worksheets on page 2 further adjust your withholding allowances based on itemized deductions, certain credits, adjustments to income, or two-earners/multiple jobs situations.

Complete all worksheets that apply. However, you may claim fewer (or zero) allowances. For regular wages, withholding must be based on allowances you claimed and may not be a flat amount or percentage of wages.

Head of household. Generally, you can claim head of household filing status on your tax return only if you are unmarried and pay more than 50% of the costs of keeping up a home for yourself and your dependent(s) or other qualifying individuals. See Pub. 501, Exemptions, Standard Deduction, and Filing Information, for information.

Tax credits. You can take projected tax credits into account in figuring your allowable number of withholding allowances. Credits for child or dependent care expenses and the child tax credit may be claimed using the **Personal Allowances Worksheet** below. See Pub. 505 for information on converting your other credits into withholding allowances.

Nonwage income. If you have a large amount of nonwage income, such as interest or dividends, consider making estimated tax payments using Form 1040-ES, Estimated Tax for Individuals. Otherwise, you may owe additional tax. If you have pension or annuity income, see Pub. 505 to find out if you should adjust your withholding on Form W-4 or W-4P.

Two earners or multiple jobs. If you have a working spouse or more than one job, figure the total number of allowances you are entitled to claim on all jobs using worksheets from only one Form W-4. Your withholding usually will be most accurate when all allowances are claimed on the Form W-4 for the highest paying job and zero allowances are claimed on the others. See Pub. 505 for details.

Nonresident alien. If you are a nonresident alien, see Notice 1392, Supplemental Form W-4 Instructions for Nonresident Aliens, before completing this form.

Check your withholding. After your Form W-4 takes effect, use Pub. 505 to see how the amount you are having withheld compares to your projected total tax for 2017. See Pub. 505, especially if your earnings exceed $130,000 (Single) or $180,000 (Married).

Future developments. Information about any future developments affecting Form W-4 (such as legislation enacted after we release it) will be posted at *www.irs.gov/w4*.

Personal Allowances Worksheet (Keep for your records.)

A Enter "1" for **yourself** if no one else can claim you as a dependent . . . . . **A** ______

B Enter "1" if:
- You're single and have only one job; or
- You're married, have only one job, and your spouse doesn't work; or
- Your wages from a second job or your spouse's wages (or the total of both) are $1,500 or less.

. . . **B** ______

C Enter "1" for your **spouse.** But, you may choose to enter "-0-" if you are married and have either a working spouse or more than one job. (Entering "-0-" may help you avoid having too little tax withheld.) . . . . . **C** ______

D Enter number of **dependents** (other than your spouse or yourself) you will claim on your tax return . . . . . **D** ______

E Enter "1" if you will file as **head of household** on your tax return (see conditions under **Head of household** above) . . **E** ______

F Enter "1" if you have at least $2,000 of **child or dependent care expenses** for which you plan to claim a credit . . . **F** ______

(**Note:** Do **not** include child support payments. See Pub. 503, Child and Dependent Care Expenses, for details.)

G **Child Tax Credit** (including additional child tax credit). See Pub. 972, Child Tax Credit, for more information.

- If your total income will be less than $70,000 ($100,000 if married), enter "2" for each eligible child; then **less** "1" if you have two to four eligible children or **less** "2" if you have five or more eligible children.
- If your total income will be between $70,000 and $84,000 ($100,000 and $119,000 if married), enter "1" for each eligible child. **G** ______

H Add lines A through G and enter total here. (**Note:** This may be different from the number of exemptions you claim on your tax return.) ▶ **H** ______

For accuracy, **complete all worksheets that apply.**

- If you plan to **itemize** or **claim adjustments to income** and want to reduce your withholding, see the **Deductions and Adjustments Worksheet** on page 2.
- If you are **single and have more than one job** or are **married and you and your spouse both work** and the combined earnings from all jobs exceed $50,000 ($20,000 if married), see the **Two-Earners/Multiple Jobs Worksheet** on page 2 to avoid having too little tax withheld.
- If **neither** of the above situations applies, **stop here** and enter the number from line H on line 5 of Form W-4 below.

---------- **Separate here and give Form W-4 to your employer. Keep the top part for your records.** ----------

Form **W-4**
Department of the Treasury
Internal Revenue Service

Employee's Withholding Allowance Certificate

▶ **Whether you are entitled to claim a certain number of allowances or exemption from withholding is subject to review by the IRS. Your employer may be required to send a copy of this form to the IRS.**

OMB No. 1545-0074

2017

1 Your first name and middle initial	Last name	2 **Your social security number**
Home address (number and street or rural route)	3 ☐ Single ☐ Married ☐ Married, but withhold at higher Single rate. **Note:** If married, but legally separated, or spouse is a nonresident alien, check the "Single" box.	
City or town, state, and ZIP code	4 **If your last name differs from that shown on your social security card, check here. You must call 1-800-772-1213 for a replacement card.** ▶ ☐	

5 Total number of allowances you are claiming (from line **H** above **or** from the applicable worksheet on page 2) **5** ______

6 Additional amount, if any, you want withheld from each paycheck . . . . . **6** $ ______

7 I claim exemption from withholding for 2017, and I certify that I meet **both** of the following conditions for exemption.
- Last year I had a right to a refund of **all** federal income tax withheld because I had **no** tax liability, **and**
- This year I expect a refund of **all** federal income tax withheld because I expect to have **no** tax liability.

If you meet both conditions, write "Exempt" here . . . . . ▶ **7** ______

Under penalties of perjury, I declare that I have examined this certificate and, to the best of my knowledge and belief, it is true, correct, and complete.

Employee's signature
(This form is not valid unless you sign it.) ▶ **Date** ▶

8 Employer's name and address (Employer: Complete lines 8 and 10 only if sending to the IRS.)	9 Office code (optional)	10 Employer identification number (EIN)

CBC FINGERPRINTING PROCESS
INSTRUCTION SHEET

NYS OPWDD regulation requires all employees and family care providers to go through the Criminal Background Check (CBC) process. Please read the instructions below carefully to ensure a smooth process.
In order to begin the fingerprinting process, an appointment must be scheduled in advance, by Tzipory Klein, Human Resources coordinator. The appointment is scheduled with you according to your time convenience.

There are a few locations that conduct fingerprinting under the auspices of OPWDD. Following are the agencies and contact information where your appointment might be taking place. The phone numbers listed below are only for reference/directions; appointments MUST be made by Tzipory Klein.

- **Metropolitan Special Services**
  1772 Flatbush Ave. Brooklyn NY, 11210 718-252-1266
- **First Alert Security Services**
  2174 Fulton St, Brooklyn, NY 11233 718-922-0214
- **Bing Secure Solutions c/o B. Liberty Builders**
  873 Route 45 2nd FL Suite 201-B New City, NY 10956 917-293-4151
- **Kerry Professional Driving School**
  800 Route 17M Suite 2B Middletown, NY 10940 (845) 343-3432

2 forms of picture ID (i.e. passport, drivers/non-drivers license, etc.) should be taken along.

If you are in need of directions to one of the locations above, you may contact our agency and we will provide you with the details. Should you need more information about the process feel free to call our Human Resources coordinator, Tzipory Klein, at 845-782-7700 Ext. 117.

Employment applications without a complete Fingerprinting process will not be accepted.

Web: www.rayim.org
Email: info@rayim.org
Fax: 845-782-7800
NYC 62 Rutledge St. #101 • Brooklyn, NY 11249 • Phone: 718.946.7700
Orange County 2 Van Buren Dr. #101 • Monroe, NY 10950 • Phone: 845.782.7700
Rockland County 3 College Rd. • Monsey, NY 10952 • Phone: 845.352.7700

Justice Center for the Protection of People with Special Needs

Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC) Unit

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	
Applicant address:	Applicant type:	
Facility/Provider: Rayim of Hudson Valley inc.		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above to must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received by DCJS and FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal history information check forwarded to the Justice Center by DCJS and the FBI shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)

☐ have been convicted of a crime in New York State or any other jurisdiction.

☐ have pending arrest charges.

If checked, provide details:

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

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List which is maintained as part of the Vulnerable Persons' Central Register and that such check is required by Social Services Law §495 and will be performed prior to the criminal history information check. 14 NYCRR Part 702 provides for the collection of social security numbers for this purpose and the failure to provide my social security number may preclude me from being considered for the position applied for.

Applicant Signature	Date:
Signature Parent/Guardian- if Applicant under 18	Date:

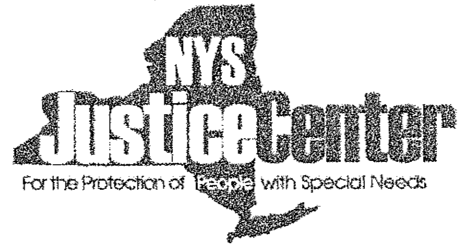
Part 3 Facility of Provider Agency Authorized Person Information

Name:	Leah Banda	**Title:**	Human Resources coordiantor
Email:	lbanda@rayim.org		
Signature:	Leah Banda		

Clear Form

Attach additional details if necessary.

Print Form

Criminal Background Check Unit 161 Delaware Avenue Delmar, NY 12054 Fax: 518-549-0464 Email: cbc@JusticeCenter.ny.gov	**Request for Criminal History Record Check**	

The purpose of this form is to formally request a criminal history record check. For state employees, DDSO should use Form OPWDD 106S.

Instructions:

1. Complete **all** fields on the form. Please print legibly.
2. Authorized person must sign and date the form.
3. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
4. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Form JC CBC Unit at PO Box 3003, Schenectady, NY 12303-0005.

Agency/DDSO /Registered Provider Name	Five Digit ID Number	Check Type
	43450	☐ DDSO ☐ Voluntary Provider ☐ Registered Provider

Applicant's Last Name	First Name	MI

Date of Birth	Social Security Number

Street Address or PO Box (applicant's)

City	State	Zip

Status (check one)	Program Type: For Voluntary Agencies enter four digit code from page 2	For Registered Providers select either:
☐ E – Employee (non state) ☐ V – Volunteer ☐ F – Family Care Provider ☐ N – Employees of vendors and contractors	0 2 1 9	☐ Transportation 0670 ☐ Subcontract Service 0880

The applicant will have regular and substantial unsupervised or unrestricted physical contact with individuals receiving services and is a subject party concerning whom a criminal history record check is required by law. The results of the criminal history record check will be used solely for purposes authorized by law. Informed consent has been given by the applicant and is on file.

Please check if applicable:

☐ The subject party is a subject party for a position which requires simultaneous criminal history record checks by both Justice Center and OASAS.

Name of Authorized Person Israel Kraus E-mail ____________

Signature of Authorized Person [signature] Date ____________

NYS Justice Center for the Protection of People with Special Needs (Justice Center)
Criminal Background Check Unit
161 Delaware Avenue
Delmar, NY 12054
Email:
cbc@JusticeCenter.ny.gov

Fingerprint Submission Authorization Form

This form provides NYS Division of Criminal Justices Services (DCJS) the information necessary to process the fingerprints that are submitted. The information is required when using LIVESCAN or when scanning prints from fingerprint cards. The form must be completed prior to presentation to the LIVESCAN operator, however, the operator will confirm that information on the form matches the physical attributes of the applicant and may change the information to reflect actual physical attributes. The LIVESCAN operator MUST confirm the identification of the applicant by means of one of the following documents which includes a photograph: valid driver's license, valid school identification document, valid passport, or valid military identification. If one of these is not available, documents that can confirm identity for employment purposes can be utilized. If "ink and roll" is being used the individual taking the prints must confirm the identification of the applicant.

Instructions:

1. Complete ***all*** fields on the form. Please print legibly.
2. If Livescan prints are being taken, give completed form to applicant to bring to Livescan location.
3. If "ink and roll" is being used, mail the completed form along with fingerprint cards and JC Fingerprint Submission Form to the JC CBC Unit at PO Box 3005 Schenectady, NY 12303-0005.

Applicant

Last Name	First Name	Middle Name	Suffix

Social Security Number	Date of Birth	Birth State	Birth Country

Citizenship	Alien Registration # if applicable	

Gender:
☐ Male ☐ Female

Race: Check the code which best describes the person.

☐ W (white) ☐ B (black)
☐ I (American Indian or Alaskan Native) ☐ A (Asian or Pacific Islander)
☐ U (Unknown) ☐ O (Other)

Eye Color: Check the eye color code which best describes the person's eye color.

☐ BLK – Black ☐ GRY – Gray ☐ MAR – Maroon ☐ XXX – Unknown
☐ BLU – Blue ☐ GRN – Green ☐ PNK – Pink ☐ MUL – Multi-color
☐ BRN – Brown ☐ HAZ – Hazel

Hair Color: Check the hair color code which best describes the person's hair color.

☐ BAL – Bald ☐ BRO – Brown ☐ SDY – Sandy ☐ BLU – Blue
☐ BLK – Black ☐ GRY – Gray ☐ WHI – White ☐ GRN – Green
☐ BLN – Blonde ☐ RED – Red ☐ XXX – Unknown ☐ ONG – Orange
☐ PNK – Pink ☐ PLE – Purple

Skin Tone	Ethnic Origin (Enter either Hispanic or Non-Hispanic)
☐ Albino ☐Light ☐Ruddy ☐Black ☐Light Brown ☐Sallow ☐Dark ☐Medium ☐Yellow ☐Dark Brown ☐Med Brown ☐Other ☐Fair ☐Olive ☐Unknown	
Weight (enter whole numbers only)	Height (enter feet and inches)
Driver's License State	Driver's License Number
Street Address	

City	State	Zip

County	Country

Applicant Type: Check appropriate response (check only one)

☐ Direct Service Provider ☐ Operator
☐ Family Care ☐ Volunteer

Aliases (this includes maiden name)

Last Name	First Name	Middle Name	Suffix

Position: Choose the appropriate type (check only one)

☐Administration	☐Food Service	☐Other Support	☐Rehabilitation
☐Other Support	☐Housekeeping	☐Physician-non-Psychiatric	☐Research
☐Direct Care	☐ Intensive Case Mgmt	☐Psychiatry	☐Residential Care
☐Clinical Ancillary Services	☐ Maintenance & Engineering	☐Psychology	☐Safety
☐Clinical Mgmt	☐ Nursing	☐Quality Assurance	☐Social Work

Justice Center/OASAS Waiver	☐ New Hire
☐ Yes ☐ No	OR ☐ Transfer from other Provider/Program/Agency

Program Code (enter four digit code from Page 3)

0219

Job Duties: Please enter detailed information about the job duties that indicate **how** the applicant will have direct and substantial unsupervised contact with persons receiving services/care and to what degree. (150 Character limit)

User Department Division – Please enter the name of the DDSO, agency or registered provider with which the applicant will be associated.

DDSO/Agency/Registered Provider Name ______________________________