Instructions for Completing the State Central Register Database Check Form

Please note that all applicants must provide their complete addresses which they have resided for the last 28 YEARS.

It is extremely important that all information on the form can 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 camp program. If the form is incomplete or illegible, it will be returned to you for corrections.

APPLICANT/HOUSEHOLD MEMBER AREA:

- First line: Indicate your name. Last name first.
- Second line: Any maiden names, previous married names, or aliases by which you have been known. Circle whether it's maiden or alias. Use additional lines if there is more than one maiden/married/alias name to be listed. **Indicate "NONE" if there are no maiden or alias names.**
- If there are no other household members, check off box ☐ if you live alone below the "Maiden/Alias" line.
- Remaining lines: Indicate the names of all household members. **All household members that live with you are to be listed in this area of the form, regardless if they are related or not. Include all adults, children and roommates.** (Attach an additional page if needed.)
  - First column: indicate the **relationship** to the applicant, of each person listed as spouse, child, family member, or other.
  - Third column: indicate the **sex**. Fill in either M (Male) or F (Female) for each person listed.
  - Last column: fill in **date of birth** (mm/dd/yy) for each person listed.

ADDRESS AREA:

- Indicate all addresses that you have resided for the last 28 years or since birth in date order.
- Complete addresses are required. Include building number, street name/number, city/town/village and zip code. **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 going back 28 years or since birth. **(Attach an additional page if needed.)**

SIGNATURE AREA:

- Only the applicant's signature is required.
- The signatures should match the applicant's name. For example, William Smith should not sign Will Smith.
- All signatures must be dated (mm/dd/yyyy). **The SCR will not accept a form with a signature date more than 6 months old.**

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):
DOHMH			M	

PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:

AGENCY NAME: New York City Department of Health & Mental Hygiene

AGENCY LIAISON: Bureau of Child Care

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 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" IN RELATIONSHIP in the fields below

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

SAMPLE

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 indicted 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 mm	dd	yy
APPLICANT	DOE	JANE	F	5	9	63
MAIDEN/ ALIAS (ALIAS circled)	SMITH					
	☐ ← Check this box if you live alone.					
SPOUSE	DOE	JOHN	M	2	1	54
SON	DOE	JOHNNY	M	7	7	83
DAUGHTER	DOE	JANICE	F	3	20	02

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 and older. Attach additional pages if necessary.

STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM	TO
CURRENT STREET ADDRESS: 10 STRAWBERRY STREET	1 FL	APPLETON	NY	10599	8/10	PRESENT
PREVIOUS STREET ADDRESS: 2 LAKE PLACE	PH	GREENTOWN	NY	10799	5/99	7/10
PREVIOUS STREET ADDRESS: 378 BROAD AVENUE	12H	LONGWOOD	NY	10999	1/93	5/99
PREVIOUS STREET ADDRESS: 123 ORANGE ROAD	6F	LEMONTOWN	NY	10699	1/90	12/92
PREVIOUS STREET ADDRESS:						

I affirm that all the information provided on this form is true. 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
Jane Doe	1/15/2018		

Camp Name: Johnny B Good Day Camp   Record ID#: 42322125

Camp Address: 75 South Camp Road, Down Town, NY 10699

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):
DOHMH			M	(646) 632-6100

PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:

AGENCY NAME: New York City Department of Health & Mental Hygiene

AGENCY LIAISON: Bureau of Child Care

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 indicted 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 mm	dd	yy
APPLICANT						
MAIDEN/ALIAS						
☐ ← Check this box if there are no other household members.						

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 and older.

CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO **PRESENT**
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM / MONTH YEAR	TO / MONTH YEAR

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

Camp Name: ____________________ Record ID#: ____________________

Camp Address: ____________________

STAPLE TO LDSS-3370 (IF NEEDED)

STATE 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	Apt #	City	State	Zip	From	To
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
					/ MONTH YEAR	/ MONTH YEAR
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STAPLE TO LDSS-3370 (IF NEEDED)

STATE 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	MM	DD	YY