LDSS-3370 (Rev. 12/2019) 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):
DIR	2005 8334		E	(516) 496- 4460

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

AGENCY NAME: COOPER KIDS THERAPY ASSOCIATES

AGENCY LIAISON: ELLEN COOPER

STREET ADDRESS: 2 ROOSEVELT AVENUE - SUITE 300

CITY: SYOSSET **STATE:** NY **ZIP CODE:** 11791

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			
			☐ M ☐ F			
			☐ M ☐ F			
			☐ M ☐ F			
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			☐ 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.

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

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) / /

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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