

New York State
Office of Children and Family Services

New York State Group Family Day Care

SAMPLE



Pursuant to the Americans with Disabilities Act, the State Office of Children and Family Services will make this material available in large print or on audiotape upon request.

SAMPLE

Your Group Family Day Care Renewal Package

Prepared For:

Your Package Includes:

Identifying Information

A-1



Requirements

B-1



Site Information

C-1



Agreements

D-1



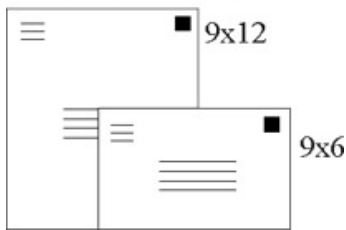
SAMPLE



Filling out the Renewal Package

This renewal application package contains only the information necessary for completing the renewal process. The checklist, "Group Family Day Care Required Documents", specifies each item which needs to be completed and submitted to complete your renewal with us. Please notice that some of the information will need to be maintained on site as well. You can use this checklist to make sure you've completed the renewal properly.

Envelope Sizes



It is not necessary to return this entire booklet to us. There are perforations on each page so you can either tear out the pages to return to us and keep the booklet, or tear out the pages you need to keep on file and mail the rest of the booklet to us.

You will need to judge what kind of envelope you will need to mail your application to us - a regular business envelope could be large enough based on the number of pages you need to send in. The illustration to the left shows two envelope sizes that could be used. The larger one will hold all of your application pages if you send in the bound package.

You should send the completed application pages to...

We look forward to working with you as you complete the renewal process.

Fingerprint Cards



If you or any household or staff member, age 18 or older, have not yet been fingerprinted, you will need to have this done. If so, please contact your licensor or registrar. Once you have been fingerprinted, use the envelope provided to return the card to...

Criminal History Review Unit
NYS Office of Children and Family Services
P.O. Box 839
Rensselaer, NY 12144-9953

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Group Family Day Care Renewal Required Documents

INSTRUCTIONS







Maintain
On-Site

- This listing specifies those documents that you are required by regulation to submit and/or maintain on-site
- Use this form to keep track of the required documents and when they are submitted
- Some documents are included in this package, some are obtained from outside sources, others you will need to create

Document Listing

- ✓ Regulation requirements
It is recommended that you maintain a copy of everything you submit

				Date Submitted (mm/dd/yyyy)
Document Name	Page	Maintain On-Site	Submit	
 Identifying Information	A-1			
General Information	A-3 and A-4		✓	/ /
Business Information	A-5 and A-6		✓	/ /
 Requirements	B-1			/ /
Provider				
Ongoing Training	B-3		✓	/ /
Medical Statement	B-5	✓	✓	/ /
Criminal History Review	B-7 and B-8		✓	/ /
Assistant				
Information	B-9		✓	/ /
Ongoing Training	B-11		✓	/ /
Medical Statement	B-13	✓	✓	/ /
Criminal History Review	B-15 and B-16		✓	/ /
Substitute				
Information	B-17		✓	/ /
Criminal History Review	B-19 and B-20		✓	/ /
Household Member(s)				
Medical Statement	B-21	✓	✓	/ /
Criminal History Review	B-23 and B-24		✓	/ /
SCR Form	B-27 thru B-31		If applicable	/ /

Group Family Day Care Renewal Required Documents (cont.)

INSTRUCTIONS








Maintain
On-Site

- This listing specifies those documents that you are required by regulation to submit and/or maintain on-site
- Use this form to keep track of the required documents and when they are submitted
- Some documents are included in this package, some are obtained from outside sources, others you will need to create

Document Listing

- ✓ Regulation requirements
It is recommended that you maintain a copy of everything you submit

Document Name	Page	 Maintain On-Site	 Submit	Date Submitted (mm/dd/yyyy)
 Site Information	C-1			
Report of Water Supply Testing	C-3	✓	✓	/ /
Fuel Burning System Inspection	C-5	✓	✓	/ /
Environmental Hazards Inspection	C-7	✓	✓	/ /
Home Safety Checklist	C-13 thru C-18	✓		/ /
 Agreements	D-1			
Child Support Obligation Statement	D-3		✓	/ /
Provider Compliance Agreement	D-5		✓	/ /
 Business Documents				
DBA (Doing Business As)	Town Clerk	as needed	as needed	/ /
Incorporation Papers	Your Attorney	as needed	as needed	/ /

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Identifying Information

General Information A-3

Business Information..... A-5

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General Information

INSTRUCTIONS



Submit

- If you have a DBA (Doing Business As) certificate and have not already submitted a copy, or if the DBA name has changed, submit it with the application
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider

Print the following information about yourself.

Mr. Mrs. Ms.

Date of Birth: / /
(mm/dd/yyyy)

Name: Last First MI

SSN / ID:

Home Address: Apt.

Phone: () Ext.

City: Floor

Unlisted: Yes No

County/Boro: State Zip

Fax: ()

Do you provide in-home care for adults or children? Yes No

E-Mail: Mailing Address (if different from home address):

If yes, please specify:

Do you speak English? Yes No
If no, please specify language spoken

DBA (if applicable):

Federal ID # (if applicable):

Site

Site Address: Apt.

Phone: () Ext.

City: Floor

Unlisted: Yes No

County/Boro: State Zip

Fax: ()

E-Mail:

Mailing Address (if different from site address):

Hours of Operation

Typical child care operating days and hours are Monday through Friday, approximately 6:00 A.M. to 7:00 P.M.

Do you plan to operate outside of these typical operating days and hours? Yes No

If yes, specify operating days and hours:

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Business Information

INSTRUCTIONS



Submit

- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- If your incorporation information changes, submit copies of the Certificate of Incorporation or Amendment and the filing receipt from the Secretary of State
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Legal Information

This information does not apply

Please check one of the boxes below and complete the following information:

- Corporation Limited Liability Company (LLC) Legal Partners
 Unincorporated Association

Legal Name: _____

Mailing Address: _____ Phone: () Ext. _____

Apt. _____ Fax: ()

City: _____ Floor _____ E-Mail: _____

State _____ Zip _____ Contact Name: _____

Contact Phone: () _____

Legal Partners, Board Members / Managers (if applicable)

List the names, titles, home addresses and phone numbers of all legal partners (including yourself). Attach additional sheets if necessary.

Name: _____		Title: _____
Last	First	MI
Address: _____		Phone: () _____
Street	City	State/Zip

Name: _____		Title: _____
Last	First	MI
Address: _____		Phone: () _____
Street	City	State/Zip

Name: _____		Title: _____
Last	First	MI
Address: _____		Phone: () _____
Street	City	State/Zip

Name: _____		Title: _____
Last	First	MI
Address: _____		Phone: () _____
Street	City	State/Zip

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Requirements

Provider

Ongoing Training	B-3
Medical Statement.....	B-5
Criminal History Review.....	B-7

Assistant

Information	B-9
Ongoing Training	B-11
Medical Statement.....	B-13
Criminal History Review.....	B-15

Substitute

Information	B-17
Criminal History Review.....	B-19

Household Member(s)

Medical Statement.....	B-21
Criminal History Review.....	B-23
SCR Instructions.....	B-26
SCR Form.....	B-27

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Provider Ongoing Training

INSTRUCTIONS



Submit

- Use this form or any other document to report the information requested below
- "Type of Training" refers to how the training was obtained (OCFS Video Conference, Classroom, Independent Study, University/College, Workshop/Conference, Red Cross, Interactive Web-Based, CBT, etc.)
- Please print clearly

Provider Name:

Group Family Day Care Program Name:

Requirements

- A total of thirty hours of training is required every two years
- Training must be completed in *each of the topics listed below*, unless exempted by the Office.

Completed Training

Topic	Dates	Titles of Training Attended	# of Hours	Sponsoring Organization or Trainer's Name	Type of Training
Business Record Maintenance and Management					
Child Abuse and Maltreatment Identification and Prevention					
Child Day Care Program Development					
Identification, Diagnosis and Prevention of Shaken Baby Syndrome					
Nutrition and Health Needs of Infants and Children					
Principles of Early Childhood Development					
Safety and Security Procedures					
Statutes and Regulations Pertaining to Child Abuse and Maltreatment					
Statutes and Regulations Pertaining to Child Day Care					
Total Hours:			<input type="text"/>		

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Provider Medical Statement

INSTRUCTIONS



Submit



Maintain
On-Site

- A Health Care Provider's signature is required in both sections of this form
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name:
Date of Birth:

Group Family Day Care Program Name:

Tuberculin Test Information

Date of Test: / /
(mm / dd / yyyy)

Mantoux Result: Positive Negative mm

If applicant was previously Positive, indicate date: / /
(mm / dd / yyyy)

If **Positive**:

Was a Chest X-ray ordered? Yes No

If No, attach health care provider's statement indicating why it was not ordered.

If Yes, is Chest X-ray normal? Yes No

If No, attach health care provider's statement documenting treatment and follow-up.

TB Test

Health Care Provider
Signature:
Name:
Title:
Phone: ()
Date: <u> </u> / <u> </u> / <u> </u> (mm / dd / yyyy)

Medical Condition

On the basis of my findings and on my knowledge of the above-named individual, I find that he/she is fit to provide child care and is not currently exhibiting signs or symptoms suggestive of a communicable disease that could be transmitted during child care. Yes No

Comments:

Medical Condition

Health Care Provider
Signature:
Name:
Title:
Phone: ()
Date: <u> </u> / <u> </u> / <u> </u> (mm / dd / yyyy)

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Provider Criminal History Review

INSTRUCTIONS



Submit

- All providers must complete and sign this form
- All providers must submit completed fingerprinting cards, regardless of conviction record
- A crime is a misdemeanor or felony only. This does not include violations such as traffic infractions and trespassing
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Fingerprinting Information

- Providers and all members of the day care household 18 years of age and older, all volunteers, assistants, substitutes and alternate providers must be fingerprinted
- Contact 1-800-732-5207 for information on how all of these fingerprints can be taken free of charge
- Your application will not be complete until all fingerprints have been submitted for processing

Conviction Statement

In accordance with Sections 390-a(2)(a) and 390-b(1)(b) of the Social Services Law, I certify that to the best of my knowledge and belief, I Have I Have Not been convicted of a crime in New York State or any other jurisdiction. If I have been convicted of a crime, I will provide true and accurate information concerning the crime for which I was convicted, the date of conviction and any other relevant information in the space provided below. In addition, I will provide written justification on the back of this sheet, explaining why I should be allowed to care for children regardless of my conviction. ***I am aware that this will be my only opportunity for this explanation to be considered in the decision to approve or deny this application.***

Record of All Convictions

EXAMPLE:	Type of Crime	Penal Code Section	Date of Conviction	County or Court of Arraignment
	Disorderly Conduct	240.20	03/17/1976	Albany

Complete the information below and submit with record of conviction or certification of court arraignment.

Type of Crime	Penal Code Section	Date of Conviction (mm / dd / yyyy)	County or Court of Arraignment
_____	_____	/ /	_____
_____	_____	/ /	_____
_____	_____	/ /	_____
_____	_____	/ /	_____

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime and/or to provide truthful and accurate information concerning the conviction(s) may constitute grounds for denial, suspension, limitation or revocation of the license or registration to provide child care at this home.

Provider Signature: _____

Date: _____
(mm / dd / yyyy)

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Assistant Information

INSTRUCTIONS



Submit

- All Assistants working in a Group Family Day Care Home must complete and sign the form below
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Assistant Name: _____

Identifying Information

Mr. Mrs. Ms.

Name: _____
Last First MI

Mailing Address: _____ Apt: _____

_____ Floor: _____

City/Borough: _____ State: _____ Zip: _____

Home Phone: () _____ E-Mail: _____

SSN / ID: _____ Date of Birth: / / _____
(mm/dd/yyyy)

- I certify that I am 18 years of age or older.
- I have received and read, and I understand New York State Office of Children and Family Services regulations for the operation of a family or group family child care home. I will be in compliance with these regulations.
- I understand that I must report to the State Central Register (1-800-635-1522) any incidents of suspected child abuse or maltreatment concerning any child in my care.
- To the best of my knowledge, the statements that I have provided in this application are true and accurate.

Assistant Signature: _____

Date: / / _____
(mm / dd / yyyy)

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SAMPLE

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Assistant Ongoing Training

INSTRUCTIONS



Submit

- Use this form or any other document to report the information requested below
- "Type of Training" refers to how the training was obtained (OCFS Video Conference, Classroom, Independent Study, University/College, Workshop/Conference, Red Cross, Interactive Web-Based, CBT, etc.)
- Please print clearly

Provider Name:

Group Family Day Care Program Name:

Assistant Name:

Requirements

- A total of thirty hours of training is required every two years
- Training must be completed in *each of the topics listed below*, unless exempted by the Office.

Completed Training

Topic	Dates	Titles of Training Attended	# of Hours	Sponsoring Organization or Trainer's Name	Type of Training
Business Record Maintenance and Management					
Child Abuse and Maltreatment Identification and Prevention					
Child Day Care Program Development					
Identification, Diagnosis and Prevention of Shaken Baby Syndrome					
Nutrition and Health Needs of Infants and Children					
Principles of Early Childhood Development					
Safety and Security Procedures					
Statutes and Regulations Pertaining to Child Abuse and Maltreatment					
Statutes and Regulations Pertaining to Child Day Care					

Total Hours:

Tear Here

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Assistant Medical Statement

INSTRUCTIONS



Submit



Maintain
On-Site

- A Health Care Provider's signature is required in both sections of this form
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name:
Assistant's Name:

Group Family Day Care Program Name:
Assistant's Date of Birth:

Tuberculin Test Information

Date of Test: / /
(mm / dd / yyyy)

Mantoux Result: Positive Negative mm

If applicant was previously Positive, indicate date: / /
(mm / dd / yyyy)

If **Positive**:

Was a Chest X-ray ordered? Yes No

If No, attach health care provider's statement indicating why it was not ordered.

If Yes, is Chest X-ray normal? Yes No

If No, attach health care provider's statement documenting treatment and follow-up.

TB Test

Health Care Provider	
Signature:	
Name:	
Title:	
Phone: ()	
Date: / / <small>(mm / dd / yyyy)</small>	

Medical Condition

On the basis of my findings and on my knowledge of the above-named individual, I find that he/she is fit to provide child care and is not currently exhibiting signs or symptoms suggestive of a communicable disease that could be transmitted during child care. Yes No

Comments:

Medical Condition

Health Care Provider	
Signature:	
Name:	
Title:	
Phone: ()	
Date: / / <small>(mm / dd / yyyy)</small>	

Tear Here

SAMPLE

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Assistant Criminal History Review

INSTRUCTIONS



Submit

- All assistants must complete and sign this form
- All assistants must submit completed fingerprinting cards, regardless of conviction record
- A crime is a misdemeanor or felony only. This does not include violations such as traffic infractions and trespassing
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Assistant Name: _____

Fingerprinting Information

- Providers and all members of the day care household 18 years of age and older, all volunteers, assistants, substitutes and alternate providers must be fingerprinted
- Contact 1-800-732-5207 for information on how all of these fingerprints can be taken free of charge
- Your application will not be complete until all fingerprints have been submitted for processing

Conviction Statement

In accordance with Sections 390-a(2)(a) and 390-b(1)(b) of the Social Services Law, I certify that to the best of my knowledge and belief, I Have I Have Not been convicted of a crime in New York State or any other jurisdiction. If I have been convicted of a crime, I will provide true and accurate information concerning the crime for which I was convicted, the date of conviction and any other relevant information in the space provided below. In addition, I will provide written justification on the back of this sheet, explaining why I should be allowed to care for children regardless of my conviction. ***I am aware that this will be my only opportunity for this explanation to be considered in the decision to approve or deny my ability to have involvement with children.***

Record of All Convictions

EXAMPLE:	Type of Crime	Penal Code Section	Date of Conviction	County or Court of Arraignment
	Disorderly Conduct	240.20	03/17/1976	Albany

Complete the information below and submit with record of conviction or certification of court arraignment.

Type of Crime	Penal Code Section	Date of Conviction (mm / dd / yyyy)	County or Court of Arraignment
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime and/or to provide truthful and accurate information concerning the conviction(s) may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license to provide child care at this home.

Assistant Signature: _____

Date: ____ / ____ / ____
(mm / dd / yyyy)

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Substitute Information

INSTRUCTIONS



Submit



Maintain
On-Site

- All substitutes must complete this form
- A substitute may care for children if you must be absent for an occasional short period of time, such as a medical appointment or an emergency
- You must maintain a list of substitutes
- Contact your Registration Office to discuss requirements for replacements for longer periods of time or regular absences
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Duplicate this page as necessary. Please print clearly

Provider Name:

Group Family Day Care Program Name:

Substitute Name:

Identifying Information

Mr. Mrs. Ms.

Name:

Last

First

MI

Mailing Address:

Apt:

Floor:

City:

State:

Zip:

Home Phone: ()

E-Mail:

SSN / ID:

Date of Birth: / /

(mm/dd/yyyy)

Tear Here

SAMPLE

SAMPLE

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Substitute Criminal History Review

INSTRUCTIONS



Submit

- All substitutes must complete and sign this form
- All substitutes must submit completed fingerprinting cards, regardless of conviction record
- A crime is a misdemeanor or felony only. This does not include violations such as traffic infractions and trespassing
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Substitute Name: _____

Fingerprinting Information

- Providers and all members of the day care household 18 years of age and older, all volunteers, assistants, substitutes and alternate providers must be fingerprinted
- Contact 1-800-732-5207 for information on how all of these fingerprints can be taken free of charge
- Your application will not be complete until all fingerprints have been submitted for processing

Conviction Statement

In accordance with Sections 390-a(2)(a) and 390-b(1)(b) of the Social Services Law, I certify that to the best of my knowledge and belief, I Have I Have Not been convicted of a crime in New York State or any other jurisdiction. If I have been convicted of a crime, I will provide true and accurate information concerning the crime for which I was convicted, the date of conviction and any other relevant information in the space provided below. In addition, I will provide written justification on the back of this sheet, explaining why I should be allowed to care for children regardless of my conviction. ***I am aware that this will be my only opportunity for this explanation to be considered in the decision to approve or deny my ability to have involvement with children.***

Record of All Convictions

EXAMPLE:	Type of Crime	Penal Code Section	Date of Conviction	County or Court of Arraignment
	Disorderly Conduct	240.20	03/17/1976	Albany

Complete the information below and submit with record of conviction or certification of court arraignment.

Type of Crime	Penal Code Section	Date of Conviction (mm / dd / yyyy)	County or Court of Arraignment
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____
_____	_____	____ / ____ / ____	_____

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime and/or to provide truthful and accurate information concerning the conviction(s) may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license to provide child care at this home.

Substitute Signature: _____

Date: ____ / ____ / ____
(mm / dd / yyyy)

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Household Member Medical Statement

INSTRUCTIONS



Submit



Maintain On-Site

- Each person residing in the home where care is being provided must have a signed medical statement
- One Health Care Provider (Physician, Physician's Assistant or Nurse Practitioner) may sign for multiple household members
- Any person who has a different Health Care Provider should use the additional space provided below
- Duplicate this page. Attach additional sheets if necessary
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Please print clearly

Provider Name:

Provider Address:

Household Members

On the basis of my findings and on my knowledge of the individuals named below, I find that no health conditions exist which would endanger children receiving child care in the home. Yes No

Household Members' Names			Date of Birth
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)

Health Care Provider
Number of individuals under my care: _____
Signature:
Name: _____
Title: _____
Phone: () _____
Date: / / (mm / dd / yyyy)

Household Members

On the basis of my findings and on my knowledge of the individuals named below, I find that no health conditions exist which would endanger children receiving child care in the home. Yes No

Household Members' Names			Date of Birth
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)
Last	First	MI	(mm / dd / yyyy)

Health Care Provider
Number of individuals under my care: _____
Signature:
Name: _____
Title: _____
Phone: () _____
Date: / / (mm / dd / yyyy)

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Household Member Criminal History Review

INSTRUCTIONS



Submit

- All persons age 18 and older residing in the home where care is being provided must complete and sign this form
- All persons age 18 and older residing in the home where care is being provided must submit completed fingerprinting cards, regardless of conviction record
- A crime is a misdemeanor or felony only. This does not include violations such as traffic infractions and trespassing
- If any of the prefilled information is incorrect, please cross out, and enter the correct information
- Duplicate this page as necessary. Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Household Member Name: _____

Fingerprinting Information

- Providers and all members of the day care household 18 years of age and older, all volunteers, assistants, substitutes and alternate providers must be fingerprinted
- Contact 1-800-732-5207 for information on how all of these fingerprints can be taken free of charge
- Your application will not be complete until all fingerprints have been submitted for processing

Conviction Statement

In accordance with Sections 390-a(2)(a) and 390-b(1)(b) of the Social Services Law, I certify that to the best of my knowledge and belief, I Have I Have Not been convicted of a crime in New York State or any other jurisdiction. If I have been convicted of a crime, I will provide true and accurate information concerning the crime for which I was convicted, the date of conviction and any other relevant information in the space provided below. In addition, I will provide written justification on the back of this sheet, explaining why I should be allowed to care for children regardless of my conviction. ***I am aware that this will be my only opportunity for this explanation to be considered in the decision to approve or deny my ability to have involvement with children.***

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Complete the information below and submit with record of conviction or certification of court arraignment.

Type of Crime	Penal Code Section	Date of Conviction (mm / dd / yyyy)	County or Court of Arraignment
_____	_____	/ /	_____
_____	_____	/ /	_____
_____	_____	/ /	_____
_____	_____	/ /	_____

To the best of my knowledge the information provided above is true and accurate. I understand that my failure to truthfully and accurately state whether I have been convicted of a crime and/or to provide truthful and accurate information concerning the conviction(s) may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license to provide child care at this home.

Household Member Signature: _____ Date: _____ / _____ / _____
(mm / dd / yyyy)

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This page was intentionally left blank so that the instruction guide and the worksheet would be side-by-side.

SAMPLE



Guide to Completing the SCR (LDSS-3370) Form

To properly complete the SCR Form, follow the instructions below.

NOTE: It is extremely important that all information provided is complete and can be easily read. Please print clearly.

• Agency Information

This section is for agency use only. Do not make any marks or corrections in this area. If information is incomplete or missing, contact your licenser or registrar for assistance.

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE				SCR USE ONLY	
AGENCY CODE	RESOURCE ID	CATEGORY <small>USE ALPHA CODE</small>	PHONE NUMBER (Area Code)	REQUEST ID	
PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:				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.	
AGENCY NAME _____				FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your child(ren) and any other persons in your home at the present time. MAKE SURE YOU COMPLETE ALL MAIDEN NAME, ALIAS SECTIONS THAT APPLY. IF NONE, STATE "NONE".	
AGENCY LIAISON _____				LINE RELATIONSHIP in the field below does <i>not</i> refer to instructions. Attach additional page if necessary.	
STREET ADDRESS _____					
CITY _____ STATE _____ ZIP CODE _____					

• 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.

1. Skip “SCR USE” column
2. **First line** (Applicant’s name) – If there is more than one applicant, write the additional name(s) on the lines below “Maiden/Alias”.
3. **Second line** – List any maiden/previous married name(s), or alias by which the applicant is or has been known. Use additional lines if there is more than one name to be listed.
4. **Remaining lines** – Indicate the name(s) 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”. Household members may be any of the following: spouse, son, daughter, mother, father, friend, etc.)
5. **Sex M/F column** – Fill in either “M” (male) or “F” (female) for each person listed.
6. **Date of Birth column** – Fill in the complete date of birth (mm/dd/yy) for everyone listed on the form.

SCR USE		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						

• Address Information

1. Provide addresses for the Family Day Care/Group Family Day Care applicant and everyone in the household who is 18 or older. This address information is required from January 1973, or from the date the individual turned 18 (if this is later than January 1973), to the present. Be sure to associate address histories with particular individuals (i.e. indicate which addresses are for which household members. Attach additional pages if necessary, but do not use another LDSS-3370 form to list this additional information.
2. 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.
3. If the individual has lived abroad, indicate country and dates of residence. If the individual has spent time in the military, list base names/locations along with dates. Be sure that there are no periods of time unaccounted for.
4. The top line is for the current address. The previous addresses should be listed from the second line downward, back to January 1973 or the individual’s 18th birthday. If additional space is needed, staple attachments to the form, but do not use another copy of the LDSS-3370 for this additional information.

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

• Signature Information

1. Signatures are required from the applicant **and** any member of the household who is 18 years of age or older. Applicants should sign in the boxes marked “Applicant’s Signature”; household members over 18 who are not applicants should sign in the boxes at the extreme bottom of the page marked “Signature”.
2. Assistants, Alternate Assistants, Alternate Providers, Substitutes and all other categories of caregiver in the FDC or GFDC home, should sign in the box marked “Applicant’s Signature”. No one else needs to sign these forms. In the instance where the day care is actually being provided in this individual’s personal residence, rather than in the residence of the primary provider, please consult with your licenser/registrar for guidance.
3. All signatures should 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*.
4. All signatures must be dated (mm/dd/yy). **The SCR will not accept forms that are more than six months old.**

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 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 Day Care provider, the information I have provided will be used to inquire of the State Central Registrar to determine if I am the subject of a indicated report of child abuse or maltreatment.			
SIGNATURE	DATE	SIGNATURE	DATE



Submit

STATE CENTRAL REGISTER DATABASE CHECK Agency Use Only

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE				SCR USE ONLY	
AGENCY CODE:	RESOURCE I.D.:	CATEGORY USE ALPHA CODE:	PHONE NUMBER (Area Code):	REQUEST I.D.:	

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

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. Children and Family Services to identify with the greatest degree of certainty, whether or not 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

SCR USE	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 since 1973, including street, city and state. For **Adoption, Foster Care and Family Day Care**, also include the same address history for household members 18 and older. If you or a household member achieved age 18 after 1973, provide addresses from that year to the present. Attach additional pages if necessary.

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

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 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 Day Care provider, the information I have provided will be used to inquire of the State Central Register to determine if I am the subject of a indicated report of child abuse or maltreatment.

SIGNATURE	DATE
-----------	------

SIGNATURE	DATE
-----------	------

Tear Here

AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY DAY CARE, if both spouses are applicants, both are to sign. Persons eighteen years old and over, residing in the home of applicants for ADOPTION, FOSTER CARE and FAMILY DAY CARE, also must sign the form.

AGENCY CODE

Record your 3 digit agency code. **NOTE:** Day Care, Family Day Care and Camps must provide the agency code of the agency or office, which issues your license or certificate. Verify your Alpha of Alpha/Numeric 3 digit code with your licensing agency.

RESOURCE I.D.

Record your RESOURCE I.D. ("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 9/01. Verify your RID with your licensing agency.

CATEGORIES

Record the appropriate category.

- F - Prospective employee (fee required - see below*)
- D - Prospective employee (Local DSS district - bill against reimbursement)**
- Y - Prospective Day Care employee
- Y - Provider of goods/services
- Y - Applying to be a group family day care assistant.
- Q - Applying to be group family day care provider.
- Z - Prospective volunteer/consultant.
- X - Applying to be adoptive parents.
- W - Applying to be foster parents or family care home providers.
- R - Applying to be kinship foster parents.
- P - Applying to be family day care provider.
- N - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.)
- M - Director of a summer camp, overnight camp, day camp or traveling day camp.
- E - Current employee.

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) (at least one person must be so designated)-USE FIRST LINE

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 NO OTHER HOUSEHOLD MEMBERS, record NONE on line below MAIDEN/ALIAS.

*Social Service Law 424-a has been amended to require the collection of fees 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 five dollars, is to accompany the form. The check also is to include the applicant's name and the agency code. N.B. **A separate check must accompany each form.** See "Operating Instructions for LDSS-3370" for more detailed instructions.

**Social Service Law 424-a has been amended to allow local DSS to bill against their reimbursement the charge collected for screening prospective employees.

**MAIL COMPLETED FORMS TO:
STATE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204**

TO ORDER MORE FORMS:

Write to: New York State Family Assistance, Bureau of Forms & Print Management, P.O. Box 1990, Albany, New York 12201.

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Site Information

Report of Water Supply Testing	C-3
Fuel Burning System Inspection.....	C-5
Environmental Hazards Inspection.....	C-7
Home Safety Checklist Guide.....	C-10
Home Safety Checklist.....	C-11

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Report of Water Supply Testing

INSTRUCTIONS



Submit



Maintain
On-Site

- All providers must complete this form regardless of testing requirement
- Sites that use a private water supply, well, or spring must have had bacterial, chemical, and physical contamination tests performed within the last 12 months
- You must provide evidence of an adequate and safe water supply that complies with state and local laws

Provider Name:

Site Address:

Provider Section – The Provider must check the appropriate box and follow the instructions provided.

Water Supply Statement

- No** The child care site **does not** use a private water supply system.
(Water testing is NOT required. Do not complete the remainder of this form.)
- Yes** The child care site **does** use a private water supply system.
(Water testing is required by an Approved Water Testing Authority/Inspector or attach the report of inspection and approval.) Contact one of the water testing authorities listed below to submit a water sample for testing.
- County Health Units (see Appendix)
 - Local Water District or Department
 - Cooperative Extension
 - Private Medical or Testing Laboratories

Water Testing Authority Section – An approved water testing authority must complete the section below.

Please read the following statement and check the appropriate box.

The water supply has been tested in accordance with health standards and is found to be:

SATISFACTORY

UNSATISFACTORY

Type of Supply Inspected: _____

Inspection Date: ____ / ____ / ____

Explanation: _____

(mm/dd/yyyy)

Signature of Inspector: _____

Telephone: () _____

Name: (Please Print) _____

Address: _____

Agency or Company: _____

Note to Provider: If the **UNSATISFACTORY** box is checked, follow the instructions below:

- Contact the County Health Unit for instructions (see Appendix for Listing)
- Explain their instructions and your plan for implementing them to provide safe drinking water at your site
- Attach any written correspondence from a County Health Unit or other testing source

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Fuel Burning System Inspection

INSTRUCTIONS



Submit



Maintain
On-Site

- All providers must complete this form regardless of inspection requirement
- Sites where any wood, coal, pellet, or other solid fuel-burning stove or fireplace, gas space heater or gas fireplace are used, must have each of these inspected
- Inspections performed within the last 12 months can be attached and submitted with this form
- If you have multiple fuel burning systems requiring inspection, duplicate this form and properly complete one for each system inspection

Provider Name:

Site Address:

Inspection Required

- Wood, coal, pellet, or other solid fuel-burning stove or fireplace
- Gas space heater
- Gas fireplace
- Wood burning furnace or boiler

No Inspection Required

- Water heater
- Kitchen stove
- Gas/Oil/Electric furnace
- Gas/Electric boiler

Fuel Burning Statement

- No** The child care site **does not** use a fuel burning system that requires inspection.
(No inspection is required. Do not fill out the remainder of this form.)
- Yes** The child care site **does** use a fuel burning system that requires inspection.
(You must complete the remainder of this form or attach a report of inspection and approval)

Inspection Information

Sources

Contact one of the appropriate authorities listed below and schedule an inspection of your fuel burning system:

- Local Fire Marshall or Inspector
- Chimney Sweeps
- Code Enforcement Officials

To Be Completed By Inspector

- The fuel burning system has been inspected in accordance with all applicable safety standards:
- Has been properly installed or is maintained in compliance with all applicable safety standards
 - Has not been properly installed or is not maintained in compliance with all applicable safety standards

Type of System Inspected:

Inspection Date: / /
(mm / dd / yyyy)

Explanation:

Signature of Inspector:

Telephone: ()

Name: (Please Print)

Address:

Agency or Company:

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Environmental Hazards Inspection

INSTRUCTIONS



Submit



Maintain
On-Site

- All Providers must complete this form regardless of inspection requirements
- Sites must be inspected where hazardous activity or conditions have been identified
- If you have multiple environmental hazards requiring inspection, duplicate this form and properly complete one for each inspection
- If you need further information, please contact the fire safety representative at the regional office
- If there is a potential environmental hazard, provide as much descriptive detail as possible

Provider Name:

Site Address:

Environmental Hazards

Sites located on or near hazardous areas would require an inspection. Such areas include:

- Dry Cleaners
- Combustible or flammable liquid including gas stations, gas refueling/ transfer/ pump stations
- Chemicals and other hazardous substances emitted into the atmosphere or seeping into the ground

Environmental Hazards Statement

Not Hazardous I have verified that this building and all its grounds and premises are not now used, nor have been used in the past, for any purpose involving a hazardous substance. No potentially hazardous conditions/activities were seen during my visual inspection of all surrounding buildings and properties.

(No testing is required. Do not fill out the remainder of this form.)

Hazardous I have identified the following potentially hazardous conditions either historically or currently in this building, grounds, or premises, or on property adjacent to or in the surrounding area.

(Record the appropriate results below and complete the remainder of this form)

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Environmental Hazards Inspection (cont.)

INSTRUCTIONS

- Only have this inspection done when requested by your licensor or registrar



Submit



Maintain
On-Site

Provider Name: _____

Site Address: _____

Inspection Information

Sources

Contact one of the appropriate authorities listed below if any potentially hazardous environment is identified:

- County Health Unit (see Appendix)
- Nuclear Regulatory Commission
- Dept. of Environmental Conservation (EnCon)
- Environmental Protection Agency (EPA)

To Be Completed By Environmental Testing Authority

<input type="checkbox"/> Air Testing	<input type="checkbox"/> Soil Testing	<input type="checkbox"/> Water Testing
<input type="checkbox"/> Does pose health hazard	<input type="checkbox"/> Does pose health hazard	<input type="checkbox"/> Does pose health hazard
<input type="checkbox"/> Does not pose health hazard	<input type="checkbox"/> Does not pose health hazard	<input type="checkbox"/> Does not pose health hazard

Hazard Inspected: _____ Inspection Date: ____/____/____
(mm/dd/yyyy)

Recommendation for Correction: _____

Signature of Tester: _____ Telephone: () _____
 Name: (Please Print) _____ Address: _____
 Agency or Company: _____

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SAMPLE



Home Safety Checklist Guide

INSTRUCTIONS

- Use the following information to complete the Home Safety Checklist



Maintain
On-Site

Purpose

- As a licensed Group Family Day Care provider, you must take suitable precautions to eliminate all conditions which may contribute to or create a fire or safety hazard.
- The purpose of this checklist is to confirm that you have taken these precautions to assure the safety of children who will be cared for in the home.
- The statements in this checklist will give you general ideas about significant safety issues that are addressed by the group family day care regulations.
- It is important that you thoroughly read and understand the regulations, which contain building, equipment, fire protection, safety and health requirements with which you must comply.

Instructions

- The applicant must complete and sign the Home Safety Checklist.
- We suggest walking through the home while completing each statement and explanation.
- After each statement there could be up to three possible answers.
 - Checking **N/A** means the situation does not exist in the group family day care home.
 - Checking **Yes** means you are in compliance.
 - Checking **No** means you are not in compliance with the requirements of the statement.
- Check the appropriate box for each statement and print clearly on all required lines.
- If any statements are confusing, or you need clarification, call your registering agency.



Home Safety Checklist

Provider Name: _____

Group Family Day Care Program Name: _____

Indicate type housing (Check all the apply):

- Single Family
 Two Family
 Multiple Family / Apt. Building
 Own the property

Child care is provided on which floor(s)? _____

Building & Equipment – Section 413.2 and Section 416.3

1.	413.2 (j)	The Group Family Day Care home structure is a legal residence in good repair.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
2.	416.3 (a)	The Group Family Day Care home heating system is properly maintained and in good working order.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
3.	416.3 (a)	Rooms used for children are well-lit and ventilated.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
4.	416.3 (d)	There are no toxic paints, finishes or hazardous materials used in or on the floors, walls, windowsills, beds, toys or any objects within reach of children. (Homes built before 1980 may contain lead paint.)	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
5.	416.3 (e)	There is no peeling paint or plaster in the home.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
6.	416.3 (j)	Hot and cold running water is provided in the child care home.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
7.	416.3 (j)	Adequate and safe water supply and sewage facilities are provided and maintained.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No

Fire Protection – Section 416.4

8.	416.4 (d)	Multipurpose, minimum 2.5 pound, ABC-type fire extinguisher is placed in the kitchen.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
9.	416.4 (d)	If the child care home is a one- or two-family house, a minimum 2.5 pound, ABC-type fire extinguisher is placed outside the furnace room.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
10.	416.4 (d)	These fire extinguishers are fully charged. This is indicated by gauges or indicating devices on the fire extinguisher.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
11.	416.4 (d)	Paper/plastic seals or pull pins on the fire extinguishers are in place and unbroken.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
12.	416.4 (d)	Caregivers know when and how to properly use fire extinguishers. (Instructions can be found on fire extinguishers.)	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
13.	416.4 (g)	If the furnace or boiler is not enclosed in its own room, garbage and other materials are not stored within four feet of the furnace or boiler.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No

Tear Here



Home Safety Checklist (cont.)

Provider Name:

Group Family Day Care Program Name:

Fire Protection – Section 416.4 (cont.)

14.	416.4 (c)	There is at least one working smoke detector located on each of the levels of the Group Family Day Care home and outside the napping areas.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
15.	416.4 (c)	Smoke detectors that are supplied with household electric power are equipped with a battery backup source, or battery-operated smoke detectors are provided in case normal power is lost.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
Where are all the smoke detectors located? _____					
17.	416.4 (e)	Children are prohibited on the third floor and higher in a single-family dwelling.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
18.	416.4 (f)	If care is provided in a one- or two-family home, there are two separate ways (remote from each other) to exit from each floor where child care is provided.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
19.	416.4 (f)	If care is provided in an apartment building, there are two separate ways (remote from each other) to exit the apartment to the street.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
20. List and describe the two exits from the home or apartment to street level. _____					

21.	416.4 (h) & 416.5 (f)	All fireplaces, chimneys, wood, coal, pellet, or other solid-fuel burning stoves and gas space heaters have been recently inspected, properly maintained, and are barricaded to prevent access by children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No

Health and Infection Control – Section 416.11

22.	416.11 (m)	Universal blood precautions are observed and disposable gloves are provided.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
23.	416.11 (g)	A portable first aid kit is accessible for emergency treatment, stocked to treat a broad range of injuries and situations, and is stored in areas out of the reach of children.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No
24. Where are your first aid kit and supplies stored? _____				

25.	416.11 (a, e, h)	You and all caregivers are familiar with your health care plan, including knowing when children are too ill to remain in your Group Family Day Care home (exclusion criteria), and the immunization requirements for children.	<input type="checkbox"/>	<input type="checkbox"/>
			Yes	No



Home Safety Checklist (cont.)

Provider Name: _____

Group Family Day Care Program Name: _____

Health and Infection Control – Section 416.11 (cont.)

26.	416.11 (k, l)	All caregivers and children wash their hands with soap and water frequently throughout the day.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
27.	416.11 (l)(1)	Children in care overnight have a routine that encourages good hygiene practices.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
28.	416.11 (l)(1)	Bathing arrangements are made between you and each child's parent.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
29.	416.11 (r)	All rooms, outdoor play areas, equipment, supplies, and furnishings are kept clean and sanitary at all times and the premises are kept free of dampness, odors, vermin, and trash.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
30.	416.11 (q)	Toilet facilities are kept clean and stocked with soap, toilet paper, and separate hand towels or disposable paper towels for children.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
31.	416.11 (r)(5)	Garbage receptacles are covered and kept in areas which are not accessible to children.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
32.	416.11 (o)	The diaper-changing area is not in the meal preparation area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A Yes No
Where is the diaper changing area? _____						

Safety – Section 416.5

34.	416.5 (a)	Firearms, weapons and all ammunition in the home are kept locked up and stored out of children's reach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A Yes No
35. Where in the home are firearms, weapons and ammunition kept? _____						
36.	416.5 (b)	Written emergency evacuation plans are posted or are on file, and accessible to parents.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
37.	416.5 (b)	Written emergency evacuation plans address notification of emergency services, alternate means of egress, evacuation methods, and care of the children once they are evacuated.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
38.	416.5 (a)	Electrical work is done only by a licensed electrician.	<input type="checkbox"/>	<input type="checkbox"/>	Yes	No
39.	416.5 (c)	Portable heating devices are prohibited in the areas accessible to children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A Yes No
40.	416.5 (d)	All radiators and pipes have been covered to prevent injury to children.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	N/A Yes No



Home Safety Checklist (cont.)

Provider Name:

Group Family Day Care Program Name:

Safety – Section 416.5 (cont.)

41.	416.5 (e)	Porches, decks, and stairs have a barrier (railing, spindles, netting, lattice, etc.) to prevent children from falling or being harmed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
42.	416.5 (a)	Stairs, walkways, ramps, and porches are maintained free of ice, snow, and other hazards.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
43.	416.5 (f)	Child safety gates have been installed to block access to stairs and other unsafe areas.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
44.	416.5 (f)	There are barriers to restrict children from areas that could be unsafe (swimming pools, open drainage ditches, wells, holes, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
45.	417.5 (g)	Only public swimming pools are used by the children. Non-public, residential swimming pools, jacuzzis, and fill-and-drain wading pools are not used.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
46.	416.5 (i)	Every electrical outlet in rooms used by children has a protective cap or cover.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
47.	416.5 (j)	All medicines (prescription and nonprescription), poisons, toxic substances, and other dangerous materials are kept in their original containers, and are stored out of children's reach.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
48.	Where are these medicines, poisons, toxic and dangerous substances stored? _____				

49.	416.5 (k)	All indoor and outdoor poisonous plants have been removed from children's reach.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
50.	416.5 (l)	Any animals present in the home pose no threat to children and are properly vaccinated according to State and local laws.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
51.	416.5 (m)	A working telephone is available with local emergency phone numbers posted by it: police, fire, ambulance, poison control centers, etc.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
52.	416.5 (a)	Children's outside play areas are clear and free of hazards (such as lawn mowers, rakes, tools, trash, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
53.	416.5 (o)	All outdoor play equipment is in good condition. All equipment is installed and used in accordance with manufacturer's instructions and placed in a safe location.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
54.	416.5 (a)	Furniture is safe and arranged so it does not present a hazard to children.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	



Home Safety Checklist (cont.)

Provider Name: _____

Group Family Day Care Program Name: _____

Safety – Section 416.5 (cont.)

55.	416.5 (p)	Clear glass panels in doors have been marked to reduce the risk of children running into them. (Place a decal, picture, etc. on the lower half.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
56.	416.5 (q)	Windows on second floor and above or less than 32 inches from the floor (measured from finished floor to the windowsill) have barriers to prevent children from falling out of windows.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No
57.	416.5 (r)	An operable battery-powered flashlight or battery-powered lantern is provided for emergencies.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
58.	416.5 (s)	The inside doors to rooms, closets, and bathrooms can be unlocked from both sides.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
How do you open locked doors in these rooms? _____					
60.	416.5 (t)	All handbags, backpacks, and briefcases belonging to adults and all items which may cause children to choke or suffocate (such as plastic bags, balloons, styrofoam objects, small toys, and parts, etc.) are placed out of children's reach.	<input type="checkbox"/>	<input type="checkbox"/>	
			Yes	No	
61.	416.5 (u)	Highchairs have a wide base and are used only by children who can sit up independently. Safety straps are fastened around children seated in high chairs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
			N/A	Yes	No

Management & Administration – Section 416.15

62.	416.15 (a)(19)	Specify the date on which you sent notification to your local Police and Fire Departments (or County Sheriff) of your hours of operation, your maximum capacity, and the age ranges of children for whom you will care Date: _____ (mm / dd / yyyy)
63.	416.15 (a)(19)	Provide the names and addresses of the Police and Fire Departments (or County Sheriff) you notified:
	Police/County Sheriff:	Fire Department/County Sheriff:
	_____	_____
	_____	_____
	_____	_____
	_____	_____

Tear Here



Home Safety Checklist (cont.)

Provider Name: _____

Group Family Day Care Program Name: _____

Transportation – Section 417.6

64. 416.6 (a)	You obtain written permission from parents before providing or arranging for transportation of any children.	<input type="checkbox"/>	<input type="checkbox"/>	
		Yes		No
65. 416.6 (d)	All children are secured in appropriately installed, age-appropriate child seats or seat belts as appropriate for the age of the child, in accordance with vehicle and traffic law.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		N/A	Yes	No

Provider Signature

The provider must complete each section of the Home Safety Checklist and sign below.

To the best of my knowledge, the information I have provided in the Home Safety Checklist is true and accurate.

Provider Signature: _____

Date: ____/____/____
(mm / dd / yyyy)

SAMPLE



Agreements

Child Support Obligation Statement..... D-3
Provider Compliance Agreement..... D-5

SAMPLE

Tear Here



SAMPLE

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Child Support Obligation Statement

INSTRUCTIONS



Submit

- Owner must complete this form unless the business is incorporated
- This form must be signed in the presence of a notary public
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Statements

As of the date of this application, do you have an obligation to pay child support?

- No, I do not.
- Yes, I am under an obligation to pay child support.

If you answered "Yes", please check any of the following conditions that apply to you.

- I am not four months or more in arrears in the payment of child support.
- I am making payments by income execution, by court agreed payment or repayment plan, or by a plan agreed to by the parties to the support proceeding.
- My child support obligation is the subject of a pending court proceeding.
- I am currently in receipt of public assistance or supplemental security income (SSI).
- None of the above apply.

I hereby solemnly swear that the information provided by me in this certification is true and accurate to the best of my knowledge. I acknowledge that this statement is given under oath.

Owner Signature: _____ Sign in the presence of a notary
Print Name: _____

Sworn to before me this _____ Day

day of _____ Month _____ Year

Notary Public – State of New York (affix stamp)

Tear Here

SAMPLE

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Provider Compliance Agreement

INSTRUCTIONS



Submit

- All providers must complete and sign this form
- Before signing the statement below, read and familiarize yourself with Part 417 of the regulations
- Please print clearly

Provider Name: _____

Group Family Day Care Program Name: _____

Program Qualifications Statements

- I certify that I am 18 years of age or older.
- I have received and read, and I understand Part 417 of the New York State Office of Children and Family Services regulations for the operation of a Group Family Day Care Home. I will operate the facility in compliance with these regulations.
- I understand that I must report to the State Central Register (1-800-635-1522) any incidents of suspected child abuse or maltreatment concerning any child in my care.

Labor & Tax Statements

- I am not an employer,
- or-
- As an employer, I certify that to the best of my knowledge and belief, I am operating my program in compliance with federal and state labor and tax laws. I am providing those employment benefits (minimum wage, social security, federal and state unemployment insurance, workers' compensation, and disability benefits) for which I am responsible. Yes No

To the best of my knowledge the statements in this application are true and accurate.

Provider Signature: _____

Date: ____ / ____ / ____
(mm / dd / yyyy)

Tear Here

SAMPLE

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