

Instructions for Completing the State Central Register Database Check Form

It is important that all information can be easily read, so that data entry and results are accurate. Each SCR Database Check form 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:

- Next to "APPLICANT," write your name, last name first.
- Next to "MAIDEN/ALIAS," list any maiden names, previous married names, or aliases by which you have been known. Select whether it is a maiden name or alias. Use additional lines if there is more than one maiden/previous married/alias name to be listed.
Indicate "NONE" if there are no maiden or alias names.
- Check the box if there are no other household members.
- Otherwise, indicate the names of all household members whether or not they are related to you. Include all adults, children and roommates. (Attach an additional page if needed.)
 - In the "Relationship to Applicant" column, indicate the relationship, of each person to you, e.g. spouse, son, family member, or other.
 - In the "Sex" column, indicate M (Male) or F (Female) - for each person listed.
 - In the last column, fill in the **date of birth** (mm/dd/yy) for each person listed.

ADDRESS AREA:

- **Provide all addresses at which you have resided for the last 28 years, starting with your current address and then working back in time. Attach an additional page if needed.**
- Complete addresses are required. Include building number, street name/number, city/town/village and zip code. P.O. box numbers are not acceptable.
- If you have lived abroad, indicate country and dates of residence. If you have spent time in the military, list base names and locations along with dates.
- **Be sure that there are no periods of time unaccounted for.**

SIGNATURE AREA:

- Only your signature is required.
- Your signature should match the name you provided in the Applicant Area. For Example, if the name you provided was "William Smith," you should not sign the form "Bill Smith."
- You must date (mm/dd/yyyy) the form next to your signature. **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 FORM

Agency Use Only

SCR USE ONLY

REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE DOHMH	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE: M	PHONE NUMBER (Area Code):
PRINT BELOW THE ADDRESS TO WHICH YOU WANT THE RESPONSE RETURNED:			<p>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.</p> <p>FOR ALL CATEGORIES: Complete the following for yourself, your spouse, your child and any other person(s) in your home at the present time. PLEASE BE SURE YOU COMPLETE ALL MAIDEN NAME/ ALIAS RELATIONSHIPS THAT APPLY. IF NONE, STATE "NONE" IN RELATIONSHIP in the fields below</p> <p>(see reverse side for instructions) Attach additional page if necessary.</p>	
AGENCY NAME: New York City Department of Health & Mental Hygiene				
AGENCY LIAISON: Bureau of Child Care				
STREET ADDRESS:				
CITY:	STATE:	ZIP CODE:		

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	SMITH					
	<input type="checkbox"/> ← Check this box if there are no other household members.					
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.

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

APPLICANT'S SIGNATURE <i>Jane Doe</i>	DATE 1/15/2021	APPLICANT'S SIGNATURE	DATE
--	--------------------------	-----------------------	------

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 FORM

Agency Use Only

SCR USE ONLY

REQUEST I.D.:

ALL INFORMATION MUST BE COMPLETE. PLEASE PRINT OR TYPE

AGENCY CODE DOHMH	RESOURCE I.D. (RID)	CHILD CARE FACILITY SYSTEM (CCFS) NUMBER:	CATEGORY USE ALPHA CODE: M	PHONE NUMBER (Area Code): (646) 632-6100
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 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.	
AGENCY NAME: New York City Department of Health & Mental Hygiene				
AGENCY LIAISON: Bureau of Child Care				
STREET ADDRESS:				
CITY:	STATE:	ZIP CODE:		

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						
<input type="checkbox"/> ← 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
-----------------------	------

Camp Name: _____

Record ID#: _____

Camp Address: _____

