Learning Care group

REFERENCE CHECK GUIDE

Applicant's Name:	School #:	Position Applied For:

REFERENCE CHECKING GUIDELINES

- A minimum of three References/Employment Verifications should be attempted for all potential hires. A minimum of two positive References/Employment Verifications ***must be completed prior to hire*** however where state licensing requirements are more stringent, state licensing guidelines should be followed.
- Applicants with limited work experience or long-term employment should still provide a minimum of two references; one personal/character reference should only be substituted in limited situations.

REFERENCE CHECK RESULTS

Confirm for ALL references completed:

Reference Form Section	Ref #1	Ref #2	Ref #3
Employment Information Verified (no discrepancies noted)	Yes No	Yes No	Yes No
General Work Performance Acceptable	Yes No	Yes No	Yes No
Work Performance with Children Acceptable	Yes No	Yes No	Yes No

Any "No's" identified above should be discussed with your District Manager prior to making a hiring decision. Along with discrepancies and fair-to-poor feedback overall, unfavorable references might include references who:

- *Were reluctant to provide any information*
- *Did not know the applicant well*
- *Refused to answer certain questions*

Reference #1	Completed by:	Date:

Employment Verification:

(Complete information in this section prior to calling reference using Application/ATS data. Verify data; note discrepancies below.)

Employer: Applicant's Position:

Hire Date: / / End Date: / /

Reason for Leaving:

Reference's Name and Title:

What is/was your relationship to the Applicant: ☐ Supervisor ☐ Peer ☐ Subordinate ☐ Other: _____

Length of Time Known: Is the applicant eligible for rehire: ☐ Yes ☐ No ☐ Unsure

Information above verified: ☐ Yes ☐ No Discrepancies Noted:

Work Performance:

Customer Service:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	**Strengths:**
Initiative:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	
Communication Skills:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	
Teamwork:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	**Developmental Areas:**
Attendance/Reliability:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	
Overall Performance:	☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ NA/Unknown	

Work Experience with Children:

Have you observed this applicant working with children? If yes, please describe how well he/she relates to children.

Are you aware of any reason why we should not allow this applicant to work with children?

Would you place your own children in the care of this person? Why or why not?

Reference #2	Completed by:	Date:

Employment Verification:

(Complete information in this section prior to calling reference using Application/ATS data. Verify data; note discrepancies below.)

Employer: Applicant's Position:

Hire Date: / / End Date: / /

Reason for Leaving:

Reference's Name and Title:

What is/was your relationship to the Applicant: ☐ Supervisor ☐ Peer ☐ Subordinate ☐ Other: _____

Length of Time Known: Is the applicant eligible for rehire: ☐ Yes ☐ No ☐ Unsure

Information above verified: ☐ Yes ☐ No Discrepancies Noted:

Work Performance:

Customer Service:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	**Strengths:**
Initiative:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Communication Skills:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Teamwork:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	**Developmental Areas:**
Attendance/Reliability:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Overall Performance:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	

Work Experience with Children:

Have you observed this applicant working with children? If yes, please describe how well he/she relates to children.

Are you aware of any reason why we should not allow this applicant to work with children?

Would you place your own children in the care of this person? Why or why not?

Reference #3	Completed by:	Date:

Employment Verification:

(Complete information in this section prior to calling reference using Application/ATS data. Verify data; note discrepancies below.)

Employer: Applicant's Position:

Hire Date: / / End Date: / /

Reason for Leaving:

Reference's Name and Title:

What is/was your relationship to the Applicant: ☐ Supervisor ☐ Peer ☐ Subordinate ☐ Other: _____

Length of Time Known: Is the applicant eligible for rehire: ☐ Yes ☐ No ☐ Unsure

Information above verified: ☐ Yes ☐ No Discrepancies Noted:

Work Performance:

Customer Service:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	**Strengths:**
Initiative:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Communication Skills:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Teamwork:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	**Developmental Areas:**
Attendance/Reliability:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	
Overall Performance:	☐ Excellent	☐ Good	☐ Fair	☐ Poor	☐ NA/Unknown	

Work Experience with Children:

Have you observed this applicant working with children? If yes, please describe how well he/she relates to children.

Are you aware of any reason why we should not allow this applicant to work with children?

Would you place your own children in the care of this person? Why or why not?

OCFS-4659 (Rev. 6/2014)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

WAIVER FOR SUBMISSION OF A DUPLICATE FINGERPRINT CARD

Please Print Clearly or Type Information

1. Last Name	2. First Name	3. M.I.	4. Sex ☒ Female ☐ Male	5. Date of Birth Month Day Year

6. Alias or Maiden Name	
7. Street Address 3 Springhurst Drive	8. Check here if this is a new address ☐
9. City/State Address East Greenbush New York	10. Zip Code 12061
11. New Facility/Provider ID# 137587	12. New Facility/Provider Name TutorTime of East Greenbush
13. New Facility/Provider Street Address 3 Springhurst Drive	
14. New Facility/Provider City/State Address East Greenbush NY	15. Zip Code 12061

16. Additional Information – Current Role *(Check One)*:

☐ D ☒ T ☐ J ☐ TR ☐ HM ☐ F ☐ A ☐ V

- D- Director/Site Operator
- T- Teacher, Assistant Teacher, Teacher's Aide Assistant in GFDC or FDC
- J- Janitor/Maintenance Staff
- TR- Transportation staff, bus drivers, van drivers, transportation aides
- HM- Household members age 18 and over
- F- Family or Group Family Day Care provider
- A- Administrative Staff
- V- Volunteer

17. Have you been previously fingerprinted by the NYS Office of Children and Family Services (OCFS) for day care employment, registration, licensure and/or by a local social services district or a voluntary authorized agency for certification or approval as a foster care/adoption parent or as someone in the household age 18 or over? ☒ Yes ☐ No

18. Please identify previous Facility/Provider/Agency below

Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address
Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address
Previous Facility/Provider ID#	Previous Facility/Provider/Agency – Name and Address

I understand that the information I have provided above will be used to complete a criminal history review. To the best of my knowledge, the information I have provided in this document is true and accurate. I also understand that my failure to provide truthful and accurate information in this document may constitute grounds for the denial, suspension, limitation, or revocation of the privileges sought in connection with this application.

19. _____ Signature _____ Date

PLEASE FORWARD THIS FORM TO YOUR LICENSING OR REGISTRATION REPRESENTATIVE

OCFS- 6002 (Rev. 08/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

QUALIFICATIONS

Child Day Care Programs

PROGRAM NAME:	FACILITY ID NUMBER:
Tutortime of East Greenbush	00137587
NAME OF PERSON WITH PENDING ROLE:	DATE OF BIRTH (mm/dd/yyyy): / /

The New York State Office of Children and Family Services (OCFS) child day care regulations identify qualifications and minimum requirements for caregiving staff in child day care programs. The information is included in section .13 of the regulations. Regulations can be obtained at ocfs.ny.gov/main/childcare/default.asp and from your licensor/registrar.

Instructions:

- Consult OCFS regulations for qualification and minimum requirements for your role.
- Complete sections that apply to your role in the program. You may attach a resume.
- You may be asked to submit additional documentation to demonstrate education, training, or child care experience.
- Please **PRINT** clearly

TYPE OF PROGRAM:	Family Day Care, Group Family Day Care and Small Day Care Centers		Day Care Center and School-Age Child Care	
ROLE IN PROGRAM	☐ Provider	☐ Volunteer	☐ Director	☐ Volunteer
	☒ Assistant	☐ Substitute	☐ Group Teacher	☒ Assistant Teacher

Education/Training (if applicable for pending role)

Date Range	Degree, Major, Name of Credential, or Training	Institution	Number of Credits (if applicable)

Child Care Experience

Date Range	Description	Location	Age of Children

Supervisory Experience (applicable for pending role of Director at Day Care Center/School-Age Child Care program)

Date Range	Description	Location

OCFS-4930 (Rev. 08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUEST FOR NYS FINGERPRINTING SERVICES
Child Care Programs

Enrollment Information:

Applicant must have an appointment to be fingerprinted. At the appointment, the applicant will need to bring this form and acceptable ID.

Appointments can be made by contacting the vendor at one of the following:
Website: https://uenroll.identogo.com/workflows/15441V or the **Call Center: 877-472-6915**

Contributor Agency Section:

Service Code: **15441V** Contributor Agency: **NYS Office of Children and Family Services-Child Day Care Programs**

Facility/Agency ID Number: 137587

Facility Name/Address: Tutorme of East Greenbush

Fingerprint Applicant Section: ☐ New Submission ☐ Resubmission

Name of Applicant:

Alias / Maiden Name:

Street Address:

City, State, & Zip:

Date of Birth: / / Sex: ☐ Male ☐ Female ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ White ☐ Black ☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander

☐ Other ☐ Unknown

Skin Tone: Eye Color: Hair Color:

Height: ft. in. Weight: lbs.

State/Country of Birth:

Role of Fingerprint Applicant (please check one):

CHILD CARE: ☐ Director (D) ☐ Provider (F) ☐ Employee/Teacher (T) ☐ Volunteer (V)
☐ Household Member over the age of 18 (HM)

Fingerprint Applicant Affirmation Section

I hereby affirm that the information contained in the application and the supporting documents are true and do not contain any false statements or omissions of any material information or facts. I understand that the making of false written statements in this application is punishable as a class A misdemeanor under Section 175.30 and/or Section 210.45 of the New York Penal Law.

Applicant's signature: X	Date: / /

Payment Section:

Agency Billing Account

OCFS-6001 (Rev. 01/2020)

Delta

NEW YOUR STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE PROVIDER, STAFF, VOLUNTEER AND HOUSEHOLD MEMBER INFORMATION

CHILD CARE PROGRAMS

INSTRUCTIONS:

- Please **PRINT** clearly. This form MUST be completed by each applicant for child care provider, staff, volunteer and household member.
- If you are not sure which role to choose, refer to the child day care regulations and/or consult with your licensor, registrar, or legally-exempt enrollment agent.
- ***List all other facility ID numbers you want your fingerprints to be associated with.***

PROGRAM INFORMATION

PROGRAM NAME:	FACILITY ID NUMBER:
FACILITY ID NUMBER OF PROGRAMS YOU WANT YOUR FINGERPRINTS ASSOCIATED WITH: , , , , , , , , ,	
BUSINESS CONTACT NAME:	
PHONE NUMBER: ( ) -	EMAIL ADDRESS:

TYPE OF PROGRAM:	Family Day Care, Group Family Day Care, Small Day Care Centers, Legally-Exempt Informal	Day Care Center, School-Age Child Care, Legally-Exempt Group	All Programs
ROLE:	☐ Provider ☐ Substitute (GFDC/FDC) ☐ Assistant (GFDC/FDC) ☐ Household Member	☐ Director ☐ Group Teacher (DCC/SACC) ☐ Assistant Teacher (DCC/SACC) ☐ Teacher (LE GROUP)	☐ Volunteer ☐ Employee

PERSONAL INFORMATION

FULL NAME (First, Middle, Last):			
DATE OF BIRTH:	GENDER:		
ADDRESS:	APT:	FLOOR:	
CITY:	STATE:	ZIP:	
PHONE NUMBER:	EMAIL ADDRESS:		

Have you ever been known by any other name? ☐ YES ☐ NO
If YES, list all known names (including maiden name, aliases, pseudonyms)_____

Have you lived in another U.S. state or territory outside of NYS in the last 5 years? Prior residence in another country does not apply. ☐ YES ☐ NO

If **YES**, complete page 2 of this form entering all out of state addresses, including U.S. territories where you lived in the past five years. **Additional information and/or forms may be required.**

If **NO**, you do not have to complete page 2.

OCFS-6003 (Rev. 09/2019)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REFERENCES

Child Day Care Program

Instructions:

- Please provide complete information for two people (one employment reference and one personal reference) we can contact.
- Relatives may **NOT** be used as references
- If you have been employed outside the home, please include an employer as one of your references
- Please **PRINT** clearly

PROGRAM NAME:	FACILITY ID NUMBER:
Time of East Greenbush	00137587
NAME:	

TYPE OF PROGRAM	Family Day Care, Group Family Day Care and Small Day Care Centers	Day Care Center and School-Age Child Care
ROLE IN PROGRAM	☐ Provider ☒ Assistant ☐ Substitute	☐ Director ☒ Teacher ☐ Volunteer

REFERENCE #1 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME (Last, First, MI):		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

REFERENCE #2 (Required)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME (Last, First, MI):		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

REFERENCE #3 (Optional)

Please check appropriate reference type: ☐ Personal ☐ Employment

☐ MR. ☐ MRS. ☐ MS.	NAME (Last, First, MI):		
BUSINESS NAME:		APT:	FLOOR:
ADDRESS:			
CITY:	STATE:	ZIP:	
DAYTIME PHONE: ( ) -	E-MAIL:		

Does reference speak English? ☐ Yes ☐ No If NO, please specify language spoken:

OCFS-6040 (6/2020)

NEW YOK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CHILD CARE EMPLOYEE, VOLUNTEER, PARENT, CHILD AND ESSENTIAL VISITORS HEALTH SCREENING ONE-TIME ATTESTATION

Before entering a child care program, employees, volunteers, parents, children and essential visitors ***must complete a health screening questionnaire daily. In addition, each employee, volunteer, parent, child and essential visitor must sign and submit this form to the program one time.*** Employees, volunteers, parents, children and essential visitors must answer all questions and take their temperature daily to confirm a body temperature lower than 100.0 degrees Fahrenheit. If anyone answers "Yes" to any of the questions below, they cannot enter the child care program. A parent or guardian is responsible for completing daily screening on behalf of their child(ren).

Self-Screening:

Below are the self-screening questions that employees, volunteers, parents, children and essential visitors are required to answer **daily**. If any of the answers to the below questions are "Yes," individuals **cannot** enter the program. If the answers are "No" to all the following questions, individuals may enter the program. If employees, volunteers, parents, children and essential visitors cannot take their temperature at home, but answer "No" to all other questions, they may report to the program to have their temperature taken on site.

1. Is your temperature higher than or equal to 100.0 degrees Fahrenheit?
2. Have you had any known contact with a person confirmed or suspected to have COVID-19 in the past 14 days?
3. Are you currently experiencing *ANY* of the following symptoms?
   - Cough (new or worsening)
   - Shortness of breath (new or worsening)
   - Trouble breathing (new or worsening)
   - Fever
   - Chills
   - Muscle pain (new or worsening)
   - Headache (new or worsening)
   - Sore throat (new or worsening)
   - New loss of taste
   - New loss of smell
4. Have you tested positive for COVID-19 through a diagnostic test in the past 14 days?

If you have answered "NO" to all questions, you have passed and may enter the program.

If you have answered "YES" to any question, you will not be allowed to enter the program.

Attestation: By signing this document, I agree that I will self-monitor these symptoms each day and report the outcome per the instructions above and will not enter any child care program if any of the above symptoms or conditions are present.

_____ _____
Signature Date

_____ _____
Signature Date

Note: *This document must be signed and returned to the program prior to entry. A signed copy needs to be provided only once. The child care program must retain a copy for their records.*

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):
				( ) -

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/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			
			☐ M ☐ F			
			☐ 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.

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

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) / /

APPLICANT NAME: _____

*APPLICANT SOCIAL SECURITY NUMBER (voluntary): _____

APPLICANT EMAIL: _____

OUT OF STATE ADDRESSES (Previous 5 years)

- PRINT CLEARLY
- YOU MAY BE ASKED TO SUBMIT ADDITIONAL FORMS FOR OUT OF STATE CLEARANCES.

Previous Street Address	City	State	Zip	From (Mo/Yr)	To (Mo/Yr)
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*Social Security Account Number (SSAN): Pursuant to the Privacy Act of 1974, any federal, state, or local government agency that requests an individual to disclose his or her SSAN, is responsible for informing the person whether disclosure is mandatory or voluntary, by what statutory or other authority the SSAN is solicited, and what uses will be made of it. In this instance the SSAN is solicited pursuant to 42 USC §9858f and New York State Social Services Law §390-b and will be used as a unique identifier to confirm your identity with other states and territories because many people have the same name and date of birth. Disclosure of your SSAN is voluntary; however, failure to disclose your SSAN may affect completion or approval of your application.

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, all 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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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: _____

Other Household Members are: (please print clearly):

☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

SCR USE ONLY	RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH mm	dd	yyyy
				☐ M ☐ F			
				☐ M ☐ F			
				☐ M ☐ F			
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				☐ M ☐ F			
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OCFS-6022 (Rev. 08/2019)
Della

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

REQUEST FOR STAFF EXCLUSION LIST CHECK

Child Day Care Programs

PROGRAM NAME: Tutortime of East Greenbush.

FACILITY ID NUMBER: 137587

The New York State Justice Center for the Protection of People with Special Needs (Justice Center) maintains a Vulnerable Persons Central Register. That register includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse. The SEL must be checked as part of the comprehensive background check process for the individuals identified below and on the **OCFS-6000** form.

Instructions:

- This form is used to check the Justice Center's (SEL).

To determine where to submit this form, find the type of program and the individual's position in the list below.

Type of program / Role in the program	Where to submit
Family Day Care, Group Family Day Care and Small Day Care Center (Staff, Volunteers, and Household Members Age 18 and older)	The licensor/registrar of the program
Day Care Center and School-Age Child Care (Directors)	The licensor/registrar of the program
Day Care Center, Legally-Exempt Group Program and School-Age Child Care (Staff and Volunteers)	The director of the program
Legally-Exempt Group Program Directors, Legally-Exempt Informal Child Care (Providers, Staff, Volunteers, and Household Members Age 18 and older)	The Enrollment Agency of the program

If the individual appears on the SEL, a determination will be made whether to hire or allow such a person to have regular and substantial contact with a child in child care programs.

Fill out all information below. Please **PRINT** clearly to avoid delays in processing.

First name: _____

Last name: _____

Middle initial:

Social security number: ___ - ___ - _____

Date of birth *Only if no social security number or alien registration number is available:* ___ / ___ / _____

Alien registration number *Only if no social security number is available:* _____

Position applied for: _____

OCFS-6005 (9//2019)
Della

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

CRIMINAL CONVICTION STATEMENT
CHILD DAY CARE PROGRAMS

INSTRUCTIONS:

- **ALL** applicants for a licensure or registration, staff, volunteers, and household members 18 years of age or older must complete and sign this Criminal Conviction Statement.
- Please **PRINT** clearly

PROGRAM NAME:	FACILITY ID NUMBER:
Tutortime of East Greenbush.	137587
PERSON'S NAME:	DATE OF BIRTH *(mm/dd/yyyy)*:

CERTIFICATION

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 other jurisdiction.**

(A crime is a misdemeanor or felony only; this does not include violations. You do not need to disclose crimes that the court designated with a "Youthful Offender" status.)

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 may constitute grounds for dismissal or denial of employment, or suspension, limitation or revocation of the license or registration to provide child care at this site.

SIGNATURE: _____ DATE: *(mm/dd/yyyy)*: / /

OCFS-6004 (08/2019) FRONT

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Instructions:

- A signature is required on BOTH SIDES of this form. If the only role is a household member, complete ony the front page.
- Only a health care provider (physician, physician assistant, nurse practitioner) may complete/sign the Medical Status section.
- **A registered nurse is NOT authorized to sign the Medical Status section but CAN sign the TB Test Information.**
- A health care professional may use an equivalent form as long as the information on this form is included.
- See additional instructions about the tuberculin test on the reverse side.
- Please **PRINT** clearly.

I attest that I have not forged or altered any information contained in this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime. In addition to potentially being subject to criminal prosecution, any program found to have submitted and/or possessed such documents may be subject to fines by the New York State Office of Children and Family Services, and/or denial or revocation of an enrollment license or registration.

Program's Name: Tutortime of East Greenbush	Facility ID Number: CO137587
Person's Name:	Date of Birth: / /

TYPE OF PROGRAM:	Family Day Care, Group Family Day Care, Small Day Care Centers	Day Care Center, School-Age Child Care, Legally-Exempt Group Programs	All Programs
ROLE:	☐ Provider ☐ Substitute ☒ Assistant ☐ Household Member (GFDC/FDC)	☐ Director ☐ Group Teacher ☒ Assistant Teacher	☒ Employee ☐ Volunteer

Typical child day care duties

- Lifting and carrying children
- Close contact with children
- Direct supervision of children
- Driver of vehicle
- Food preparation
- Desk work
- Facility maintenance
- Evacuation of children in an emergency

Following to be completed by health care provider ONLY

Medical status

To the best of my knowledge of the above-named individual, I find that:			
They are currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a diagnosed psychiatric or emotional disorder that would pose a risk to the health and safety of children in care.	☐ YES	☐ NO	
They have a physical condition that would prevent them from providing typical child day care duties as described above.	☐ YES	☐ NO	☐ NA *(if only role is volunteer or household member)*
For any "YES" responses, clarify and/or indicate restrictions:			

Signature *(physician, physician's assistant, nurse practitioner)*

Title

Name *(please PRINT clearly or use office stamp)*

Date of Exam

( )
Phone

/ /
Date of Signature

(Continued on reverse side)

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

STAFF, VOLUNTEER, AND HOUSEHOLD MEMBER MEDICAL STATEMENT

Child Care Programs

Program's Name: TutorTime of East Greenbush	Facility ID Number: 1375987
Person's Name:	Date of Birth:

Instructions:

- **Household members** in a family-based program that have no other role **do not need to have** a tuberculin test and do not need to complete this page. No one with a role in a legally-exempt program needs to complete the turberculin test.
- A health care professional (physician, physician's assistant, nurse practitioner) *or a registered nurse as part of his/her duties at a health care facility*, may enter the results in the tuberculin test information section and sign this page.
- Acceptable tuberculin tests include Mantoux or other federally approved tuberculin test.
- Please **PRINT** clearly.

Following to be completed by health care professional ONLY

Tuberculin test information

Test completed

Test read on: ___/___/___ (mm / dd / yyyy)

Test result: ☐ Positive ☐ Negative _____ mm

If positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

Test not completed

☐ Not tested. Provide reason: _____

_____
Medical Exemption or Contraindication

If test result was previously positive, indicate date: ___/___/___ (mm / dd / yyyy)

If previously positive, does this person's contact with children enrolled in child care pose a risk to the children's health and safety?
☐ Yes ☐ No

_____
Signature *(physician, physician's assistant, nurse practitioner or registered nurse)*

_____ _____
Name *(please PRINT clearly or use office stamp)* Title

( ) - ___/___/___
Phone Date

INSTRUCTIONS FOR PROGRAMS TO RETURN THE FORM:

- **GFDC/FDC programs**—return this completed form to your licensor or registrar.
- **DCC/SACC programs-directors**—return this completed form to your licensor or registrar; all other staff—return the form to the director for evaluation.
- **Directors of legally-exempt group programs**—return this form to your enrollment agency.
- **Employees and volunteers at legally exempt programs**—return this form to your director

Field Employee Handbook Acknowledgment of Receipt

LCG360

I acknowledge that I have received the Learning Care Group Field Employee Handbook and I understand it is my responsibility to read and follow the policies in the Field Employee Handbook.

I also understand that once I am employed, I can access the Field Employee Handbook online on the Employee Lounge or by clicking on the Field Employee Handbook icon on all classroom iPads. I further acknowledge that if I am unable to access the Field Employee Handbook online, I can contact my Manager or the Human Resources Pay and Benefits Connection at 1-877-767-5241 option 2 for assistance.

The policies in this Handbook govern my employment with the Company, and I agree that I will follow them. I understand that I may ask my Manager and/or the Human Resources department any questions concerning the Handbook.

I acknowledge that failure to comply with any requirements listed, as well as the failure to follow Company policy, state and federal laws, regulations, and/or licensing guidelines may result in corrective actions up to and including separation of employment.

I understand that this Handbook is not a contract of employment, express or implied, between me and the Company and that I should not view it as a contract of employment.

I understand that my employment status is at-will and acknowledge that employment can be terminated by me or the Company at any time and for any reason, with or without cause and with or without notice.

I understand that this Handbook supersedes any previous handbooks or addendums issued and any prior statements or representations regarding the terms and conditions of my employment with the Company whether written or oral. I also understand and agree that the Company reserves the right to change or alter policies at any time with or without notice. Only a designated representative of the Company has the authority to modify the Handbook.

_____	_____
Employee Name	**School #**
_____	_____
Employee Signature	**Date**

USE OF COMPANY EQUIPMENT ACKNOWLEDGEMENT

LCG360

The undersigned employee of Learning Care Group, Inc. (the "Company") must adhere to the Use of Company Equipment Agreement. Company Equipment includes, but is not limited to, computers, software, air cards for laptops, cell phones, digital cameras, credit cards, memoranda, sales brochures, manuals, building keys and passes.

Loss, damages, or theft of Company property should be reported to management immediately. Negligence in the care and use of Company property may be considered grounds for discipline, up to and including termination.

Employees released from employment for any reason, including resignation, discharge, medical termination, etc., must return all Company-owned equipment on the last day of work.

If the equipment is damaged or missing components in any way, the Company reserves the right to charge the employee for the appropriate amount to fix or replace the equipment or its missing parts. If equipment is lost or stolen because of an employee's negligence, it is the responsibility of the employee to cover the expense of replacing the equipment. The Company reserves the right to withhold pay from an employee who has not covered such expenses and take other action as legally permitted.

The undersigned agrees that, should there be any outstanding expense related to the use of Company-owned equipment, Learning Care Group is hereby authorized to withhold or deduct without notice such charges from any wages that from time to time are due and owing by the undersigned.

_____ _____

Employee's Printed Name Date

_____

Employee's Signature

CODE OF CONDUCT ACKNOWLEDGMENT FORM

LCG360

I acknowledge that I have received and read the Learning Care Group Code of Conduct. I understand that the Code contains important information regarding the Company's standards, principles and policies.

I agree to comply with all of the obligations contained in the Code during my employment with the Company, including a shared duty to prevent, correct and, if necessary report suspected Code violations.

Print Name: _____

Signature: _____

Date: _____

Notice and Acknowledgement of Pay Rate and Payday
Under Section 195.1 of the New York State Labor Law
Notice for Hourly Rate Employees

1. Employer Information

Name:
(Location)

Doing Business As (DBA) Name(s):

FEIN (optional):

Physical Address:

Mailing Address:

Phone:

2. Notice given:

___ At hiring

___ On or before February 1

___ Before a change in pay rate(s), allowances claimed or payday

3. Employee's rate of pay:

$ _____ per hour

4. Allowances taken:

___ None

___ Tips _____ per hour

___ Meals _____ per meal

___ Lodging _____

___ Other _____

5. Regular payday: _____

6. Pay is:

___ Weekly

___ Bi-weekly

___ Other

7. Overtime Pay Rate:

$ _____ per hour (This must be at least 1½ times the worker's regular rate, with few exceptions.)

8. Employee Acknowledgement:

On this day I have been notified of my pay rate, overtime rate (if eligible), allowances, and designated payday on the date given below. I told my employer what my primary language is.

Check one:

☐ I have been given this pay notice in English because it is my primary language.

☐ My primary language is _____. I have been given this pay notice in English only, because the Department of Labor does not yet offer a pay notice form in my primary language.

_____
Employee Name Empl ID

_____
Employee Signature

_____
Date

_____
Preparer's Name and Title

The employee must receive a signed copy of this form. The employer must keep the original for 6 years.

PAYSLIP REQUEST FORM

LCG360

You currently have access to your payslip electronically by logging in to LCG360. You can also print copies of your electronic payslips from LCG360.

You have the option to only receive electronic access to your payslip or you can choose to receive a paper copy. Please make one selection below, sign this form and deliver it to HRISTeam@learningcaregroup.com

☐ I choose to only have electronic access to my payslips through LCG360.

☐ I choose to receive a paper copy of my payslips. I am responsible and agree to update my information with any address changes in my personal record in LCG360.

Employee ID: _____ School Number/Location: _____

Employee Name: [First] _____ [Last] _____

Employee Signature: _____ Date: _____

Please scan/email completed form to HRISTeam@learningcaregroup.com

CHILDTIME LEARNING CENTERS Nurturing in every way. · La Petite ACADEMY Together, we learn. · montessori unlimited Where self-discovery happens. · The Children's Courtyard FORWARD THINKING · TUTOR TIME LEARNING CENTERS · Everbrook ACADEMY · CREATIVEKIDS LEARNING CENTER · Pathways LEARNING ACADEMY