Instructions for Completing the OPWDD Form 159 OPWDD Registered Provider Request for Statewide Central Register Database Check Form

ALL information must be entered using the fillable form. No handwritten forms will be accepted. Each SCR Database Check submitted should be reviewed for completeness. If the form is incomplete, it will be returned to the agency for additions/corrections.

THE PROPER WAY TO COMPLETE THE FORM:

REGISTERED PROVIDER/AGENCY AREA:

- Registered Provider Name: Please use full name, no abbreviations.
- Agency Name: Please provide if applicable.
- Street Address including, City, State and Zip Code.

REGISTERED PROVIDER/AGENCY INFORMATION:

- Authorized Person's Name is the person who is authorized to submit CBC requests.
- Phone number (with area code) enables the OPWDD SCR Checks staff to contact the authorized person if this is necessary.
- Email Address: Enables the OPWDD SCR Check staff to respond to the authorized person.

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.
- Remember to **type** all information in order to assist in obtaining an accurate response. Record all names with the last name first, then the first name, and middle name.
- First line: Applicant's name.
- Second line: Any maiden names, previous married names, or aliases by which the applicant is or has been known. Use additional lines if there is more than one maiden/married/alias name to be listed.
- Remaining lines: Names of all other household members. (Attach additional page if needed-OPWDD Form 159b.)

If there are no other household members, indicate NONE on the line below "Maiden/Alias".

- First column: Indicate the relationship to the applicant of each person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F column: Fill in either M (Male) or F (Female) for every person listed.
- Date of Birth column: Fill in complete date of birth (mm/dd/yy) for everyone listed on the form.

ADDRESS AREA:

- Provide addresses for the applicant. This information must be provided for the last 28 years. Attach supplemental pages (OPWDD 159a) if necessary, but **do not use** another OPWDD Form 159 to list this additional information.
- Complete addresses are required. Include street name and city/town/village, zip code. Also include street number and apartment number. **Post Office Box** numbers **are not acceptable.** If the applicant has lived abroad, indicate country and dates of residence. If the applicant has spent time in the military, list base names and locations along with dates. **Be sure that there are no periods of time unaccounted for.**

SIGNATURE AREA:

Signatures required:

- Applicants must sign in both boxes marked "Applicant's Signature".
- All signatures must 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.
- All signatures must be dated (mm/dd/yy).
- Authorized persons must sign in the appropriate box marked "Authorized Person's Signature."

If you have questions regarding proper completion of this form, **please call 518-473-7032 or email:** SCR.Check@opwdd.ny.gov

EMAIL COMPLETED OPWDD FORM 159 TO: SCR.Check@opwdd.ny.gov

TO ACCESS THE OPWDD FORM 159:

http://www.opwdd.ny.gov Click on the Justice Center logo and look under "Pre-employment checks."

OPWDD Form 159 (1/2/2014) FRONT

OPWDD Use Only
Date Submitted
Reference ID #

OPWDD Registered Provider Request for STATEWIDE CENTRAL REGISTER DATABASE CHECK

ALL INFORMATION MUST BE COMPLETE AND TYPED

REGISTERED PROVIDER NAME:	
AGENCY NAME: (if applicable)	Select Human Services, a Division of New Hope Community, Inc.
STREET ADDRESS:	17-19 Marble Avenue
CITY:	Pleasantville
STATE & ZIP CODE:	NY 10570

AUTHORIZED PERSON'S NAME:
Darlene Dosin

AUTHORIZED PERSON'S PHONE NUMBER:
(914) 741 - 6300

AUTHORIZED PERSON'S EMAIL ADDRESS:
ddosin@selecthumanservices.org

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

Attach additional page(OPWDD Form 159a or 159b) if necessary.

The purpose of collecting the demographic data on *other persons in your household* who are not screened pursuant to Section 424-a of the Social Services Law is to enable the N.Y.S. Office of Children and Family Services to identify with the greatest degree of certainty whether the person(s) being screened is the subject of an 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

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 for the last 28 years, including street, city, state and zip code.

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

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

I authorize the New York Statewide Central Register of Child Abuse and Maltreatment (SCR) and the Office for People with Developmental Disabilities to furnish all information which may be contained within the SCR to the above named registered provider. If there is an indicated report as a result of the SCR check, I authorize the above named registered provider to contact the appropriate investigating entity to receive further information with regard to the incident indicated in the report.

APPLICANT'S SIGNATURE	DATE

I certify that I am an authorized person at the above named registered provider and am authorized to receive the information pertaining to criminal background checks. I understand that the information must be kept confidential in accordance with 14 NYCRR 633.24(c)(6).

AUTHORIZED PERSON'S SIGNATURE	DATE

OPWDD Form 159a

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM ADDITIONAL PAGE

(Use only if the space on the OPWDD Form 159 is not sufficient)

APPLICANT NAME: ______________________________

All dates must be consecutive.

Previous Street Address	City	State	Zip	From	To

OPWDD Form 159b
OPWDD Registered Provider Request for

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the OPWDD Form 159 is not sufficient)

APPLICANT NAME: ______________________________

Other Household Members:

OPWDD Use Only	Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
				M/F	M	D	Y