(Rev. 09/2018)

CATHOLIC CHARITIES ARCHDIOCESE OF NEW YORK 100 YEARS PROVIDING HELP CREATING HOPE

CATHOLIC CHARITIES VOLUNTEER INFORMATION FORM

Basic Information

First Name:	Last Name:	
Mailing Address:		
City:	State:	Zip:
Home Telephone:	Cell:	
Date Of Birth:		
Email Address:		

Best Time to Contact You:
Preferred Method of Contact (email, phone call, text):

Volunteer Experience

Volunteer Interests:
Languages:

Organization Name:	
City, State:	Approx. Dates:
Description of Volunteer Work:	

Other Volunteer Experiences:

Skills or Talents (Please share any special skills/talents! Volunteers are often able to fulfill needs not listed on our website):

Work Experience

(present or last employer)

Company Name:	Title:
City, State:	Approx. Dates:
Primary Tasks:	

Other Work Experiences:

Would you be willing to provide our agencies with pro bono professional assistance?

Yes ◯ No ◯ Maybe ◯

Emergency Contact Information

Primary Contact:

Name:	Relationship To You:
City, State:	Telephone Number:

Secondary Contact:

Name:	Relationship To You:
City, State:	Telephone Number:

CATHOLIC CHARITIES ARCHDIOCESE OF NEW YORK 100 YEARS PROVIDING HELP CREATING HOPE

RELEASE, WAIVER AND INDEMNIFICATION

I hereby freely, voluntarily, and without duress execute this release under the following terms:

I understand this is a legally-binding release ("Release") made by me, my parent or legal guardian, if applicable, to Catholic Charities of the Archdiocese of New York and/or Catholic Charities Community Services of the Archdiocese of New York (herein referred to as "Agency"). I understand that I am expected to fulfill my commitments to trainings and the tasks assigned to me. I agree to contact Agency staff if I am unable to participate in an activity for which I have been registered.

ASSUMPTION OF RISK: As a volunteer, I fully recognize that there may be direct, indirect or inherent risks and hazards involved in the activity of volunteering and it is with full knowledge of the facts and circumstances surrounding this activity and to the extent permitted by the laws of the State of New York that I release Agency, the Archdiocese of New York, the Archbishop of New York, its agencies, employees, agents, partners and representatives from any liability whatsoever arising out my participation in any volunteering activity. I also understand that Agency does not require me to participate in any volunteering activity, but I want to do so, despite the possible dangers and risks and despite this Release.

I also agree to assume all of the risks and responsibilities in any way associated and understand that this Release shall bind the members of my family and spouse, if I am alive, as well as my estate, family, heirs, administrators, personal representatives or assigns, if I am deceased, and shall be deemed as a "Release, Waiver, Discharge and Covenant" not to sue Agency. I further agree to save and hold harmless, indemnify and defend Agency, the Archdiocese of New York, the Archbishop of New York, its partners and its representatives from any claim by me or my family, arising out my participation referenced herein. If any term of this Release shall be held illegal, unenforceable, or in conflict with any law governing this Release, the validity of the remaining portions shall not be affected thereby.

I assure Agency that there are no health-related reasons or problems which preclude or restrict my participation as a volunteer and that I have adequate health insurance necessary to provide for and pay for any medical costs that may directly or indirectly result from my participation.

INDEMNITY: In consideration of and return for the services, facilities, and any other assistance provided me by Agency, it is my express intent to indemnify and hold harmless Agency, the Archdiocese of New York, the Archbishop of New York, its representative agencies, and partners, herein releasing Agency, the Archdiocese of New York, the Archbishop of New York and its representatives from any and all liability, claims and/or actions that may arise from injury or harm to me, either from my death or from damage to my property in connection with volunteering with Agency.

CONFIDENTIALITY: I acknowledge that I am prohibited from removing or disclosing confidential or proprietary Agency information of which I may become aware while volunteering with the Agency. Confidential and proprietary information includes, but is not limited to: (i) consumer or client information; (ii) relationships with businesses and benefactors; (iii) Protected Health Information ("PHI"); (iv) proprietary correspondence and donor financial contributions; (v) financial information, business plans, budgets, revenue, expense figures or projections, and strategy information; and (vi) agreements or other information required by law or contract to be kept confidential.

PHOTO RELEASE: I hereby consent to the taking of photographs, movies, videos, and images capable of reproduction in any medium of me, my children, or children of whom I am the designated guardian by Agency and its parents, affiliates, trustees, directors, members, officers, employees, volunteers, agents and contractors. I hereby grant Agency the right to edit, reproduce, use and re-use said images for any and all purposes including, but not limited to, advertising, promotion, display and marketing and commercial purposes, and I hereby consent to the editing, reproduction, use and re-use of said images in any and all media in existence and all media not yet in existence including, but not limited to, video, print, television and Internet and Pod-Casts.

MEDICAL TREATMENT: I hereby release and forever discharge Agency from any claim whatsoever which arises or may hereafter arise on account of any first aid, treatment, or service rendered in connection with my activities with Agency. AGENCY EXPECTS AND ENCOURAGES EACH VOLUNTEER TO OBTAIN HIS/HER OWN MEDICAL OR HEALTH INSURANCE COVERAGE.

I hereby confirm, represent and warrant that I have never been convicted of or charged with a violent crime, child abuse or neglect, child pornography, child abduction, kidnapping, rape or any sexual offense, nor have I ever been ordered by a court to receive psychiatric or psychological treatment in connection therewith.

By agreeing to this Release, I warrant that I have read and fully understand this Release and I am fully familiar with its contents and terms. I agree to this Release freely and without inducement or assurance of any nature.

IN WITNESS WHEREOF, I am of legal mental capacity to act as my own representative in agreeing to this Release.

NAME:

SIGNATURE: _____

DATE:

CATHOLIC CHARITIES ARCHDIOCESE OF NEW YORK 100 YEARS PROVIDING HELP CREATING HOPE

Voluntary Self-Identification of Disability

Why am I being asked to complete this form?

Because we do business with the government, we must reach out to, hire, and provide equal opportunity to qualified people with disabilities. To help us measure how well we are doing, we are asking you to tell us if you have a disability or if you ever had a disability. Completing this form is voluntary, but we hope that you will choose to fill it out. If you are applying for a job, any answer you give will be kept private and will not be used against you in any way.

If you already work for us, your answer will not be used against you in any way. Because a person may become disabled at any time, we are required to ask all of our employees to update their information every five years. You may voluntarily self-identify as having a disability on this form without fear of any punishment because you did not identify as having a disability earlier.

How do I know if I have a disability?

You are considered to have a disability if you have a physical or mental impairment or medical condition that substantially limits a major life activity, or if you have a history or record of such an impairment or medical condition.

Disabilities include, but are not limited to:

- Blindness
- Autism
- Bipolar disorder
- Post-traumatic stress disorder (PTSD)
- Deafness
- Cerebral palsy
- Major depression
- Obsessive compulsive disorder
- Cancer
- HIV/AIDS
- Multiple sclerosis (MS)
- Impairments requiring the use of a wheelchair
- Diabetes
- Epilepsy
- Schizophrenia
- Muscular dystrophy
- Missing limbs or partially missing limbs
- Intellectual disability (previously called mental retardation)

○ NO, I DON'T HAVE A DISABILITY

○ I DON'T WISH TO ANSWER

○ YES, I HAVE A DISABILITY (or previously had a disability)

AUTHORIZATION & DISCLOSURE FOR BACKGROUND CHECK

I have received the "Disclosure Regarding Background Investigations", "A Summary of Your Rights Under the Fair Credit Reporting Act", and a copy of Chapter 23-A of the New York State Corrections Law, and I understand my rights as described in those documents. I hereby authorize Catholic Charities of the Archdiocese of New York, the Archdiocese, their affiliates and agents, Catholic Mutual Group, and LexisNexis Screening Solutions Inc. ("LexisNexis"), during the evaluation of my candidacy for employment with Catholic Charities, and throughout the course of my service with Catholic Charities, to the extent permitted by law, to conduct the following background checks: criminal history, sex offender registration, credit history, social security verification, and motor vehicle records.

Further, the information received in connection with this background checks is strictly confidential and will not be released except to the personnel specified in the *Archdiocesan Policy on Background Checks.* Unless I so authorize in writing, the Archdiocese and its independent contractors will not disclose or distribute the information generated from the background checks listed above.

I hereby authorize, without reservation, any law enforcement agency, administrator, state or federal agency, institution, school or university (public or private), information service bureau, employer, or any other company or individual to furnish any and all background information requested by Catholic Charities, the Archdiocese, their affiliates, agents, and LexisNexis. To the extent permitted by law I release all individuals, companies, corporations and agencies from any and all liability, claims, and or damages relating to the above-authorized background checks. I agree that a fax, electronic or photographic copy of this Authorization shall be as valid as the original.

I affirm that all information provided in this Authorization is true and correct to the best of my knowledge.

Name: _____

Prefix First Middle Last Suffix

If any other name (e.g., nickname or maiden name) is necessary to complete a background check, please list the name(s) here:

_____

Current Address:

_____

Address	**City**	**State**	**Zip Code**	**Years at Address**

Prior Address:

_____

Address	**City**	**State**	**Zip Code**	**Years at Address**

Date of Birth: _____

Month Day Year

Date of Birth is *REQUIRED*; information is used for identification purposes only. Age is in no way used as a qualification for employment or volunteer service.

Social Security Number: _____

Social Security Number is *REQUIRED; if the individual is a foreign citizen and does not have an Social Security Number, a Government Issued picture ID must accompany this form for processing.*

Driver's License Number: _____ **State of Issuance:** _____

Telephone: _____ _____

Home Cell

_____

Signature Date

Instructions for Completing the Statewide Central Register Database Check Form

LDSS-3370

- **ALL** information on the form must be easily read so that data entry and results are accurate. Each SCR Database Check submitted should be reviewed for completeness and legibility by the program/agency liaison. If the form is incomplete or illegible, it will be returned to the agency for corrections.

THE PROPER WAY TO COMPLETE THE FORM:

AGENCY INFORMATION

TOP LINE OF FORM:

- The three-digit agency code must be placed in the top left-hand box, followed by the Resource I.D. (RID) in the next box to the right. (Contact the licensing agency if there are any questions about these.)
- Daycare providers must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID number. (Contact your licensing agency/Regional Office if you have any questions).
- Clearance Category letter code (see back of Form LDSS-3370) must be placed in the middle box.
- Phone number (with area code) enables the SCR to contact the agency liaison if this becomes necessary.
- The Request ID Box is for SCR use only.

AGENCY ADDRESS AREA:

- Agency Name: Please use full name, no abbreviations
- Agency Liaison is the contact person at the inquiring agency. (*The SCR response will be addressed to the liaison.) **The liaison cannot be the applicant or a relative of the applicant.**
- Agency Address: Must include street, city

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 **write clearly** or **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. If there is more than one applicant place the additional name(s) on the lines below the maiden name line.
- 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 an additional page if needed.)

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:

The information required varies depending on the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care (see back of form for categories), provide addresses for the applicant and any household member who is 18 and older**. We need this information for the last 28 years.** Attach supplemental pages if necessary, but **do not use** another LDSS-3370 form to list this additional information. Be sure to associate address histories with particular individuals *(i.e., indicate which addresses are for which household members).*
- For all other categories, only the applicant's address history is required – for the last 28 years.
- 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.** 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.**
- The top line is for the current address. The previous address should be listed on the second line downward, and so on to the back of the form for the last 28 years. Staple the attached supplemental page to the form if more space is needed, but do not use another copy of the LDSS-3370 for this additional information.

SIGNATURE AREA:

Signatures required depend upon the particular category:

- For Adoption, Foster Care and Family and Group Family Day Care *(see back of form for category)*, signatures are needed from the applicant and any household member who is 18 or older.
- For all other categories, only the applicant's signature is required.
- 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.
- Applicants must sign in the boxes marked "Applicant's Signature", household members over 18 who are not applicants must sign in the boxes at the extreme bottom of the page marked "Signature".
- All signatures must be dated *(mm/dd/yy).* The SCR **will not accept** a form with a signature date more than 6 months old.

If you have questions regarding proper completion of this form, **please call the SCR at 518-474-5297.**

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

STATEWIDE CENTRAL REGISTER
P.O. BOX 4480
ALBANY, N.Y. 12204-0480

TO ORDER A SUPPLY OF LDSS-3370 FORMS:

Please access the (OCFS-4627) **Request for Forms and Publications**, from the Intranet: http://ocfs.state.nyenet/admin/forms/SCR/ Internet: http://ocfs.ny.gov/main/forms/cps/ and mail the completed OCFS-4627 Request for Forms and Publications, to:
THE OFFICE OF CHILDREN AND FAMILY SERVICES, RESOURCE DISTRIBUTION CENTER, 11 FOURTH AVE, RENSSELAER, NY 12144.

LDSS-3370 (Rev. 09/2014) 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 CODE:	PHONE NUMBER **(Area Code):**
132	20043766		Z	(212) 371 - 1000

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

AGENCY NAME: Catholic Charities Community Services

AGENCY LIAISON: Joy V. Jasper

STREET ADDRESS 1011 First Avenue, 6th Floor

CITY: New York **STATE:** NY **ZIP CODE:** 10022

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. 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

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 and state. For Adoption, Foster Care, Family and Group Family Day Care, also include the same address history for household members 18 of age and older.

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
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

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 or Group Family Day 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

SIGNATURE	DATE

STAPLE TO LDSS-3370 *(IF NEEDED)*

STATEWIDE CENTRAL REGISTER DATABASE CHECK FORM
ADDITIONAL PAGE

(Use only if the space on the LDSS-3370 form is not sufficient)

APPLICANT NAME: _____

Print clearly, All dates must be consecutive. Be sure to associate address histories with particular individuals

Previous Street Address	City	State	Zip	From	To

NEW YORK STATE
OFFICE OF CHILDREN AND FAMILY SERVICES

NOTIFICATION OF SOCIAL SERVICE LAW 424-a PROCEDURES

(Please read both sides carefully. It may impact upon your employment or service to this agency)

Section 424-a of the Social Services Law requires authorized agencies, including local social services districts, the Office of Children and Family Services, special act school districts, residential schools which are operated, supervised or approved by the education department and licensed day care centers to inquire whether a person actively being considered for employment who will have the potential for regular and substantial contact with children being cared for by the agency is the subject of an indicated report of child abuse or maltreatment on file with the State Central Register of Child Abuse and Maltreatment. This section also requires these same agencies to make such an inquiry regarding an individual or an employee of an individual, corporation, partnership or association which provides goods or services to the agency and who has or will have the potential for regular and substantial contact with children authorized agencies, including local social services districts, the Office of Children and Family Services special act school districts, residential schools which are operated, supervised or approved by the education department and licensed day care centers to make inquiries to the State Central Register regarding any current employee, any person who has volunteered his or her services to the agency or any person to be hired as a consultant who has or will have the potential for regular and substantial contact with the children being cared for by the agency.

This agency will make such an inquiry to the State Central Register regarding you based on the position for which you have applied, are being considered or which you currently occupy. You will be notified by the New York State Office of Children and Family Services if the result of this inquiry shows that you are the subject of an indicated report of child abuse or maltreatment.

If the State Central Register replies to our inquiry that you are the subject of an indicated report of child abuse or maltreatment, this agency must consider that factor, along with other back ground information, in determining whether to employ you, retain you as an employee, use you as a volunteer, hire you as a consultant, or allow you access to provide goods or services to this agency. You may be asked to provide details of the situation(s) or incident(s) that gave rise to the indicated report. You may also be asked to sign a release allowing this agency to receive a copy of the indicated report on file with the State Central Register.

If you are denied employment, terminated as an employee or volunteer, not accepted as a volunteer, not hired as a consultant or denied access to the agency to provide goods or services, you will be provided with a written statement from this agency which sets forth the reason(s) for the denial. If the denial is based, in whole or in part, on the existence of an indicated report of child abuse or maltreatment, the statement will include that basis in the explanation of the denial.

(Continued on the Back)

LDSS-3371A (Rev 2/2004)

If you are notified that you have been denied or dismissed from employment, have not been hired as a consultant, have been dismissed or not accepted as a volunteer, or denied access to the agency to provide goods or services because you are the subject of an indicated report of child abuse or maltreatment, you will be informed at that time of your right, pursuant to Sections 22 and 424-a of the Social Services Law, to request a hearing before the Office of Children and Family Services on the indicated report on file with the State Central Register.

Given to: _____

List of Name(s) _____

_____

_____

_____

By: Joy V. Jasper
Name

For Catholic Charities Community Services
Agency

_____
Date

R**eviewed** 2/2013

CAPA Applicant Inquire Process

ACKNOWLEDGEMENT BY APLICANT OF THE PROCESS WHEREBY THE APPLICANT'S HISTORY INRELATIONSHIP TO POSSIBLE CHILD ABUSE OR MALTREATMENT IS CHECKED AT THE STATE CENTRAL REGISTER OF CHILD ABUSE AND MALTREATMENT

I, _____
(name of applicant – type or print)

☐ have
☐ have not

been a subject of an indicated report of child abuse or maltreatment. (An indicated report of child abuse or maltreatment is a report on file with the Statewide Central Register of child Abuse and Maltreatment the New York Office of Children and Family Services because some credible evidence exists to support that you have been involved in a case of child abuse and/or maltreatment.)

I have received notice of the requirements of Social Services Law 424-a, and I understand that if information regarding my past history with the Statewide Central Register of Child Abuse and Maltreatment is contained in a report from the Register, it will be used to determine my suitability to take a position that involved regular and substantial contact with individuals receiving services. I further understand that may misrepresentation of my status or of the information given will result in administrative action which may include dismissal or discipline.

_____
(Applicants signature)

_____
(Date)

Note: A form such as this should be completed by all applicants who have the potential for regular and substantial contact with individuals served by the provider agency. It would be used to record the fact that an applicant has been informed that a background check will be made for possible indicated cases of child abuse or maltreatment. The Child Abuse Prevention Act requires that such notification be made.