



**Volunteer
Transportation
Center, Inc.**

Main Office: 24685 Route 37 Watertown, New York 13601

Jefferson (315) 788-0422 Lewis (315) 376-3777

St. Lawrence (315) 714-2034 Genesee (585) 250-5030

Erie (716) 713-0611 Oswego (315) 714-9134

Become a Volunteer Driver—Today!

Becoming a Volunteer Driver is rewarding. You meet friendly people, experience the gratification of assisting someone in need and are reimbursed for miles driven. As a Volunteer Driver you set your own schedule and have the flexibility of donating as much time as you are able.

To become a volunteer you must—

- Have a valid driver's license, clean driving record, valid registration and insurance
- Have patience and tolerance.
- Be fair, friendly, and accepting.
- Possess warmth and sensitivity with the ability to care.
- Consent to a background check

New Driver Application Checklist

- ☐ Driver Application
- ☐ Copy of your current driver's license
- ☐ Copy of your current car insurance
- ☐ Copy of your current registration
- ☐ Background check consent form

Jefferson/Lewis County ONLY

- ☐ Two letters of reference
- ☐ Department of Social Services Release Form
- ☐ Statewide Central Register Database Check Form (address history for the last 28 years)

Interested? Simply complete the short application and return it to the VTC office in the county where you reside. Or email info@volunteertransportation.org



**Volunteer
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24685 Route 37 Watertown, New York 13601
(315) 788-0422 Fax (315) 788-8021

6587 Highway 11, PO Box 515 Canton, NY 13617
(315) 714-2034 Fax (315) 788-8021

Volunteer Driver Application

Full application available at VolunteerTransportationCenter.org

Driver Information		Check where you reside:				
		<input type="checkbox"/> Jefferson/Lewis <input type="checkbox"/> St. Lawrence <input type="checkbox"/> Genesee <input type="checkbox"/> Erie <input type="checkbox"/> Southern Tier <input type="checkbox"/> Oswego				
Name:						
Date of birth: / /		SSN: - -		Driver's License ID#		DL Expiration: ____/____/____
Mailing address:						
City:		State:		ZIP Code:		
Home Phone:				Cell Phone:		
Physical address (if different):						
City:		State:		ZIP Code:		
Traffic Violations in the Last 3 Years? (attach a copy of a valid driver's license)						
◇ No		◇ Yes (please explain)				
Convicted of Misdemeanor(s), Felony(s), or other Crimes?						
◇ No		◇ Yes				
Date:		Violation:				
Availability						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Restrictions?						
Are you able to help others in & out of vehicles?				◇ No	◇ Yes	
Are you able to help with wheelchairs & walkers?				◇ No	◇ Yes	
Are you able to help others in & out of buildings?				◇ No	◇ Yes	
Vehicle Information						
Attach copies of vehicle registration and current insurance card for each vehicle used for volunteering.						
Vehicle 1	Make/Model	Year 20_____	Insurance Expiration	Registration Expiration	Plate #	
Vehicle 2	Make/Model	Year 20_____	Insurance Expiration	Registration Expiration	Plate #	
<p>Please read the following statement. I acknowledge I will be reimbursed for distance traveled from my home and back to my home while driving <i>scheduled</i> clients for the VTC. My automobile insurance will remain in effect; VTC's insurance coverage is secondary liability only. All requests for transportation will be screened and approved through the VTC. A Transportation Coordinator will contact you for specific dates and times. If accepted, you agree to abide by VTC guidelines, including completion of required vouchers indicating client and the miles driven. Vouchers will be provided by the VTC. The vouchers should be completed at the end of each run and turned in weekly to the VTC (due each Thursday by 4pm). You may hand deliver, mail, fax or email vouchers in pdf or jpg format.</p> <p><i>Please note the Volunteer Transportation Center does not discriminate. The eligibility of each driver is not based on age, race, color, or religious beliefs. Eligibility is based on the information provided by you as well as the references.</i></p>						
Signature of applicant:				Date:		

Volunteer Background Report Disclosure and Authorization

Authorization to Obtain Background Check

Volunteer Transportation Center, Inc. may obtain from Verified Volunteers, 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860. www.verifiedvolunteers.com, a report ("REPORT") that contains background information about you in connection with volunteerism. Verified Volunteers may obtain further reports throughout your volunteerism so as to update your report without providing further disclosure or obtaining additional consent.

The REPORT may contain information about your character, general reputation, personal characteristics and mode of living. The REPORT may include, but is not limited to, criminal and other public records and history; public court records; motor vehicle and driving records; and Social Security verification and address history, subject to any limitations imposed by applicable federal and state law. This information may be obtained from public record and private sources, including government agencies and judicial records, and other sources.

Volunteer Signature _____ Date _____

Disclosure Regarding Background Report

I have read the above disclosure provided by Volunteer Transportation Center, Inc. and this Authorization to Obtain Volunteer Background Report. By my signature below, I hereby consent to the preparation by Verified Volunteers, a reporting agency located at 113 South College Avenue, Fort Collins, CO, 80524, (855) 326-1860, www.verifiedvolunteers.com, of background reports regarding me and the release of such reports to the VTC and its designated representatives, to assist the VTC in making a volunteer decision involving me at any time after receipt of this authorization and throughout my volunteerism, to the extent permitted by law. To this end, I hereby authorize, without reservation, any state or federal law enforcement agency or court, educational institution, motor vehicle record agency, or other information service bureau or data repository, to furnish any and all information regarding me to Verified Volunteers and/or the VTC itself, and authorize Verified Volunteers to provide such information to the VTC. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

Volunteer Signature _____ Date _____

First Name: _____ Middle: _____ Last: _____

Social Security Number: _____ Email: _____

Date of Birth: _____ Phone Number: _____

Driver's License #: _____ Driver's License State: _____

Other Names Used (alias, maiden name, etc.):

Alias: _____ Dates alias used: from _____ to _____

Alias: _____ Dates alias used: from _____ to _____

Alias: _____ Dates alias used: from _____ to _____

Alias: _____ Dates alias used: from _____ to _____

Volunteer Information

Address History

Address 1: _____ from _____ to _____

Address 2: _____ from _____ to _____

Address 3: _____ from _____ to _____

Address 4: _____ from _____ to _____

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, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

- **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 (*mo/yr*) of residence. If the applicant has spent time in the military, list base names and locations along with dates (*mo/yr*). **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.ny.net/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, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 134 NORTH, RENSSELAER, NY 12144-2834.**

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): () -
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 <u>FOR ALL CATEGORIES:</u> 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 <i>(see reverse side for instructions) Attach additional page if necessary.</i>	

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

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F	DATE OF BIRTH
APPLICANT				
APPLICANT MAIDEN/ALIAS/MARRIED NAME				

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 (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 / /	APPLICANT'S SIGNATURE	DATE / /
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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 / /
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AGENCY LIAISON INSTRUCTIONS

Please verify that each form is completed. Incomplete forms will be returned to the sender. For ADOPTION, FOSTER CARE, and FAMILY and GROUP 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 AND GROUP FAMILY DAY CARE also must sign the form.

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

DAYCARE PROVIDERS - Must place their Child Care Facility System (CCFS) Number in the box next to Resource ID (RID), in lieu of Resource ID (RID) number. (Contact your licensing agency/Regional Office if you have any questions).

RESOURCE I.D. (RID) - 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 RID'S as of 9/01. Verify your RID number with your licensing agency. If you need assistance, email: ocfs.sm.conn_app@ocfs.ny.gov

CLEARANCE CATEGORIES - Record the appropriate category.

<p>A – Adult Services/Family Type Home for Adults</p> <p>D - Prospective employee (<i>Local DSS district - bill against reimbursement</i>)**</p> <p>E - Current employee.</p> <p>F - Prospective/new employee other than day care employees. (fee required - see below)*</p> <p>M - Director of a summer camp, overnight camp, day camp or traveling day camp.</p> <p>N - Applying for a license to operate a day care center. (To be submitted by authorized licensing agency only.) (fee required - see below)*</p> <p>P - Applying to be family day care provider. (fee required - see below)* <i>Provide address history for all household members 18 and over.</i></p>	<p>Q - Applying to be group family day care provider. (fee required - see below)* <i>Provide address history for all household members 18 and over.</i></p> <p>R - Applying to be kinship foster parents.</p> <p>S - Provider of goods/services</p> <p>U – Universal Pre-K Teacher (fee required - see below)*</p> <p>W - Applying to be foster parents or family care home providers.</p> <p>X - Applying to be adoptive parents pursuant to an application pending before the inquiring agency.</p> <p>Y - Prospective <u>Day Care</u> employee (fee required - see below)*</p> <p>Z - Prospective volunteer/consultant.</p>
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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 THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK BOX FOR NO OTHER HOUSEHOLD MEMBERS.

*Social Service Law 424a requires the collection of a \$25.00 fee 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 twenty-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.

**Social Service Law 424a, allows local DSS to bill against their reimbursement the charge collected for screening prospective employees.

If you have questions, please call the SCR at 518-474-5297.

MAIL YOUR COMPLETED LDSS-3370 FORM TO:

**STATEWIDE CENTRAL REGISTER
P.O. BOX 4480, Attention: Service Center Unit
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, FORMS AND PUBLICATIONS UNIT, 52 WASHINGTON ST. ROOM 134 NORTH, RENSSELAER, NY 12144-2834**. If you have difficulty accessing a form on either site, you can call the automated Forms Request Line at **518-473-0971**.

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 (*mo/yr*). Be sure to associate address histories with particular individuals.

[illegible]

Other Household Members are (please print clearly):
☐ **IF THERE ARE NO OTHER HOUSEHOLD MEMBERS, PLEASE CHECK THIS BOX.**

[illegible]

**NYS Justice Center for the
Protection of People with
Special Needs
(Justice Center)
Criminal Background Check Unit
161 Delaware Avenue
Delmar, NY 12054
Fax: 518-549-0464**

Request for Staff Exclusion List Check Form



The Justice Center maintains a Vulnerable Persons Central Register (VPCR) that includes a Staff Exclusion List (SEL) containing the names of individuals who have committed serious acts of abuse and are deemed ineligible to work in a position involving regular and substantial contact with a service recipient. Providers must request the Justice Center to conduct a check of the SEL before determining whether to hire or otherwise allow “any person” to have regular and substantial contact with a service recipient. “Any person” can include an employee, administrator, consultant, intern, volunteer, or contractor.

Instructions:

1. The provider’s Authorized Person must complete this form and fax it to the Justice Center’s Criminal Background Check (CBC) unit for an applicant under serious consideration to be hired or otherwise permitted to have regular and substantial contact with a service recipient.
2. The Justice Center’s CBC unit will send the Authorized Person an email indicating the results of the SEL check.
3. If the Applicant is on the SEL, he or she may not be hired in a position involving regular and substantial contact with a service recipient in a facility or provider agency defined in Social Services Law §488(4) or by other providers of services in programs licensed or certified by the Office of Mental Health, Office for People With Developmental Disabilities, Office of Alcohol and Substance Abuse Services, Office of Children and Family Services, Department of Health and State Education Department.
4. If the Applicant is on the SEL, certain other providers have discretion whether to hire the individual as provided in Social Services Law §495(3).
5. If the Applicant is not on the SEL, a criminal background check through the Justice Center, if required, and an inquiry of the Statewide Central Register of Child Abuse and Maltreatment through the Office of Children and Family Services, if required, must be conducted.

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Social Security Number:	Alien Reg#:
Applicant address:	Applicant type:	
Facility/Provider Name: Address:		
State Oversight Agency: OMH OPWDD OCFS DOH SED OASAS		<u>Please circle appropriate agency(ies)</u>

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)		Email:
Signature:		Phone:
Facility/Provider name:		Address: