IN FLIGHT
INNOVATION for
DEVELOPMENTAL
ACHIEVEMENT

Employment Verification Request

Release of Information: I hereby authorize In Flight, Inc. to investigate all information pertinent to my application for employment to determine my qualifications for employment, which may include contacting former and/or current employers or any person or entity. I hereby authorize all persons and entities having information relevant to my application to provide that information to In Flight, Inc. I understand that any offer of employment may be rescinded, or my employment terminated if my references are inadequate or unacceptable to In Flight, Inc., or if I violate any of the provisions of the Certification.

Name of Applicant: _____

Signature of Applicant: _____ Date: _____

Previous Employer: _____ Contact Person: _____

Position Held: _____ Dates of Employment: _____

Please return to Cassandra Crespo, Human Resources Assistant, via FAX at (845) 835-4125

To be filled out by Previous Employer:

Please Clarify the Following:

Previous Position Title: _____

Dates of Employment: From: _____To: _____

Name: _____ Title: _____
(of person supplying information)

Contact Information: _____

Signature: _____

DISCLOSURE AND RELEASE

In connection with my application for membership or employment (including contract for services) with _____, I understand that consumer reports, which may contain public record information, may be requested and obtained.
(Organization)

These reports may include information related to my previous driving record including court actions, citations, license suspensions and revocations.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right to obtain information as to the name, address and phone number of any agency providing such information and further, may request of that agency, upon proper identification, the nature and substance of all information in its files on me at the time of my request, including all sources of information as well as the recipients of any reports on me which that agency has previously furnished within the two (2) year period preceding my request.

This authorization shall remain on file and shall serve as ongoing authorization for the organization to procure Motor Vehicle Reports at any time during my employment, membership or contract period.

_____ _____
Print Name Social Security Number

_____ _____
Signature Date

_____ _____
Driver License Number State

_____
date of birth

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: In Flight Inc. Address: PO Box 326 Red Hook, NY 12571		
State Oversight Agency: OMH (OPWDD) OCFS DOH SED OASAS		**Please circle appropriate agency(ies)**

Part 2. Authorized Person Information Please print clearly

Name: (Please Print)	Teresa Stivala	Email:	tstivala@inflightinc.org
Signature:		Phone:	845-835-6060
Facility/Provider name:	In Flight Inc.	Address:	PO Box 326 Red Hook, NY 12571

Fingerprint Applicant Info Sheet

Applicant Name First Name_____ Last Name_____

Date of Birth: _____

Methods of Contact (*If there is a problem with the prints, MorphoTrust requires a way to reach out to the Applicant to advise that they need to be re-printed.*)

Preferred Contact Method (check one): Phone ☐ Email ☐

Phone Number _____

Email_____(*not required unless preferred method of contact)*

Citizenship

Country of Birth: _____

If US, state of birth: _____

Country of Citizenship: _____

Personal Questions

Have you ever used a maiden/previous name? Yes ☐ No ☐

Have you ever used an alias? Yes ☐ No ☐

Is your mailing address the same as your residential address? Yes ☐ No ☐

Personal Info

Height: ___ Feet ___ Inches Weight: ____

Eye Color:
- Black ☐
- Blue ☐
- Brown ☐
- Gray ☐
- Green ☐
- Hazel ☐
- Maroon ☐
- Pink ☐

Hair Color:
- Bald ☐
- Black ☐
- Blond ☐
- Brown ☐
- Gray ☐
- Red ☐
- Sandy ☐
- White ☐

Preferred language: _____ Gender: Male ☐ Female ☐ Race:
- American Indian ☐
- Asian ☐
- Black ☐
- White ☐
- Unknown ☐

Ethnicity: Hispanic ☐ Non-Hispanic ☐ Unknown ☐

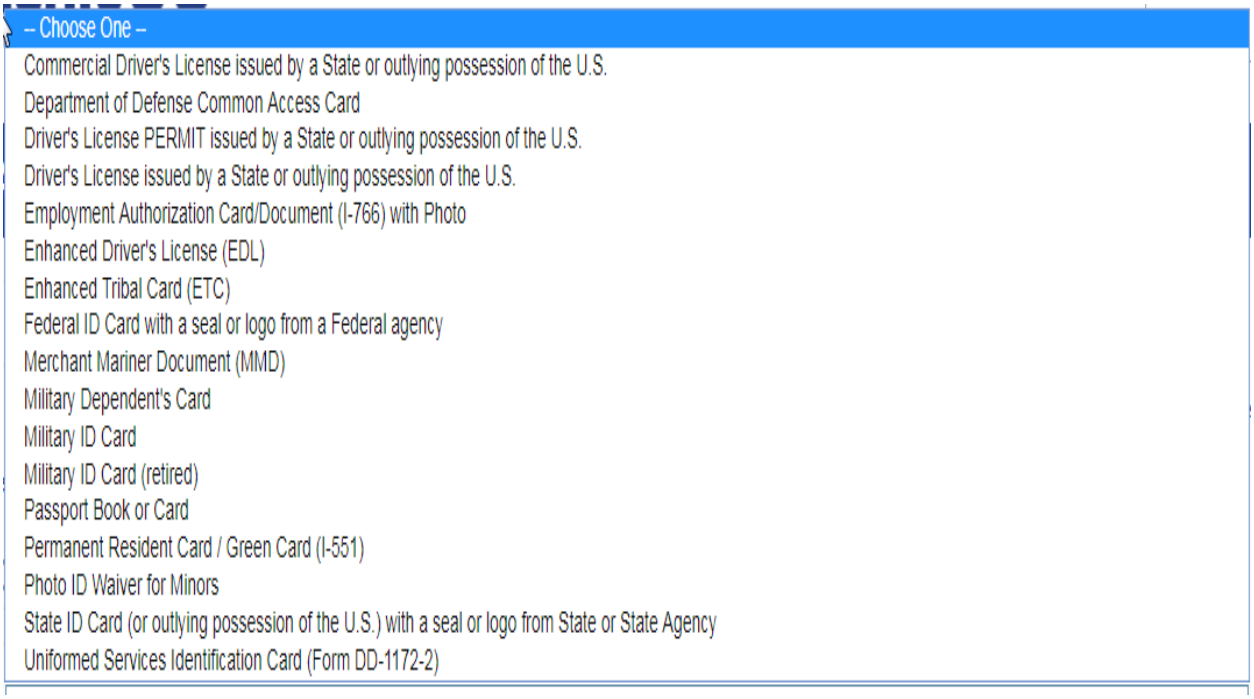
Applicant Home Address Number Street Name

Unit Designator (Apt # **required** If applicable)

Country City State Zip Code

Identification Document

Please select the required documents to bring to your enrollment.



Does the name you are enrolling under match the name on the document selected? Yes ☐ No ☐

NEW YORK STATE OF OPPORTUNITY. Justice Center for the Protection of People with Special Needs	**Applicant Consent Form for Fingerprinting for Justice Center Criminal Background Check (CBC)**	**NYS Justice Center for the Protection of People with Special Needs (Justice Center) Criminal Background Check Unit**

Part 1. Applicant Information (Please Print)

Last Name:	First Name:	MI:
Date of Birth:	Applicant type: Employee_____ Volunteer___ Family Care___Operator_____	
Applicant address, city state:	Social Security Number:	
Facility/Provider Name:		

Part 2. Attestation

1. I have been advised that as part of the application process, the facility or provider agency listed above must request a background check with the NYS Division of Criminal Justice Services (DCJS) and the Federal Bureau of Investigation (FBI) and the Justice Center must review and evaluate the results received from DCJS and the FBI. A conviction for certain crimes may affect my suitability for employment in this position.
2. I consent to having my fingerprints taken and submitted to DCJS and the FBI and consent to the Justice Center sharing with the facility or provider agency listed above a summary of the NYS criminal history information, if any, returned by DCJS, as part of its background investigation of my suitability for employment or volunteer service, or for certification as a natural person operator.
3. I have been advised that procedures exist for me to obtain, review and, if necessary, seek correction of my criminal history information pursuant to regulations established by DCJS in 9 NYCRR Part 6050, and the FBI, as applicable.
4. I have been advised that I have the right to withdraw my application for employment or volunteer service, or certification as a natural person operator, without prejudice, any time before employment, volunteer service, or certification as a natural person operator is offered or declined, regardless of whether the authorized person of the facility or provider agency has reviewed the summary of any criminal history information.
5. I have been advised that the results of the criminal background check forwarded to the Justice Center shall be confidential pursuant to the applicable federal and state laws, rules and regulations, and shall only be disclosed to persons authorized by law. Criminal history information will be considered pursuant to Article 23-A of the NYS Correction Law in making hiring determinations.
6. I affirm that the fingerprints submitted will be my own and that the information I have provided is true, complete and accurate.
7. I certify to the best of my knowledge that I: (check as appropriate)
   (a) ____have not been convicted of a crime.
   (b) ____have been convicted of a crime in NY or other jurisdiction.
   (c) ____ have pending arrest charges.
   If (b) or (c) is checked, provide details:_____
   _____
   _____
   _____

You have not been convicted of a crime if:
a. Your conviction was sealed; dismissed; reversed; resulted in a youthful offender (YO) or juvenile delinquency (JD) adjudication; resulted in a conviction for a non-criminal violation offense; or if you were acquitted;
b. you received an Adjournment in Contemplation of Dismissal (ACD) and the adjournment period has elapsed; or
c. you withdrew your plea after completing a treatment program, and were not convicted of a felony or misdemeanor.

8. I have been advised that my social security number is being requested so that the Justice Center may check whether I am on the Staff Exclusion List as required by Social Services Law and will be performed prior to the criminal history information check.

Applicant Signature		Date:
Guardian signature if under 18		Date:
Part 3	**Facility or Provider Agency Authorized Person Information**	
Authorized Person Name:	Teresa Stivala	Title: Vice President of Human Resources
Signature:		Email: tstivala@inflightinc.org

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. Handwritten forms will not 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. Each applicant should be submitted to OPWDD individually, only one request per email and the form must be submitted by an Authorized Person from the agency.

THE PROPER WAY TO COMPLETE THE FORM:

REGISTERED PROVIDER:

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

REGISTERED PROVIDER 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, please check box for no other household members.

- First column: Indicate the relationship to the applicant of every person listed. (Spouse, son, daughter, mother, father, friend, etc.)
- Sex M/F/X column: Fill in either M (Male) or F (Female) or X (Unspecified or another gender identity), for every person listed.
- Date of Birth column: Fill in complete date of birth (mm/dd/yyyy) for every person listed.

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.
- Include month and year (mm/yyyy) in all "FROM" and "TO" boxes.
  - -You may include "Current" or the date the form is signed in the "TO" box for the current address only.
- 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/yyyy).
- Authorized persons must sign in the appropriate box marked "Authorized Person's Signature."
- OPWDD will not accept a form with a signature date more than six months old.

If you have questions regarding proper completion of this form, **please email:** SCR.Check@opwdd.ny.gov

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

TO ACCESS THE OPWDD FORM 159

Go to Hiring a New Employee and scroll down to "**Statewide Central Registry Database Check**" and scroll down to "Resources"

OPWDD Form 159 (6/12/2024) 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: In Flight, Inc.

STREET ADDRESS: 7539 North Broadway/PO Box 326

CITY: Red Hook

STATE & ZIP CODE: NY, 12571

AUTHORIZED PERSON'S NAME: Teresa Stivala

AUTHORIZED PERSON'S PHONE NUMBER: 845-835-6060

AUTHORIZED PERSON'S EMAIL ADDRESS: tstivala@inflightinc.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

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

RELATIONSHIP TO APPLICANT	LAST NAME	FIRST NAME	SEX M/F/X	DATE OF BIRTH mm/dd/yyyy		
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. All dates must be consecutive and include month and year (mm/yyyy).

STREET ADDRESS	**APT #**	**CITY**	**STATE**	**ZIP**	**FROM mm/yyyy**		**TO mm/yyyy**	
CURRENT STREET ADDRESS	APT #	CITY	STATE	ZIP			Date or `Current'	
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP				
PREVIOUS STREET ADDRESS	APT #	CITY	STATE	ZIP				

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 AND INCLUDE MONTH AND YEAR (MM/YYYY).

STREET ADDRESS	APT #	CITY	STATE	ZIP	FROM mm/yyyy		TO mm/yyyy	

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:

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

Relationship To Applicant	Last Name	First Name	Sex	Date of Birth		
			M/F/X	M (mm)	D (dd)	Y (yyyy)