NEW YORK STATE OF OPPORTUNITY.

Justice Center for the Protection of People with Special Needs

Authorized Person Designation Form Justice Center Staff Exclusion List (SEL) Check

Criminal Background Check Unit
Fax: 518-549-0464
Email: cbc@JusticeCenter.ny.gov

The purpose of this form is to designate the Authorized Person for your agency who will be permitted to request, on behalf of the Provider Agency, a check of the Staff Exclusion List (SEL) pursuant to relevant statutory authority. By signing this form, each signatory attests that all requests made by the Authorized Person for a check of the SEL by the Justice Center on each prospective employee, volunteer, consultant or natural person operator ("subject individual") will be made in conformance with the law.

INSTRUCTIONS:

1. Please complete all Parts of this form.
2. The Authorized Person must sign Part 1 and the Director of the Provider Agency must sign Part 2 and date this form where indicated, one form for each Authorized Person.
3. Please return the completed form to the Justice Center. The form may be scanned and emailed, or faxed to the Justice Center's CBC Unit at the contact information above.

Part 1. Authorized Person

Last Name:	First Name:	M. I.:
Business Email Address:	Business Phone	
Full Provider Name: (Please avoid abbreviations)		
Business Address:		
City:	State:	Zip:

I understand that my designation as an Authorized Person is granted for the sole purpose of performing responsibilities related to a request for a check of the SEL pursuant to relevant statutory authority. I agree that such requests will be made solely to carry out those specific responsibilities. I further understand that the results of a SEL check will only be used and disseminated for purposes authorized by law, and I agree to abide by the confidentiality requirements set forth in Social Services Law §496, Labor Law §203-d and Article 6-A of the Public Officers Law.

Signature of Authorized Person:	Date:

Part 2. Provider Approval (DIRECTOR OF THE PROVIDER AGENCY MUST APPROVE DESIGNATION OF AUTHORIZED PERSON BY SIGNING BELOW)

I hereby designate the person identified in Part 1 of this form to serve as the Authorized Person for the Provider as noted on this form. I also request access and appropriate permission for this person to request a check of the SEL in support of this responsibility.

Name	Title:
Director's Signature:	Date:

Part 3. Provider State Oversight Agency Information

Office of Mental Health (OMH) Agency Code:	
Office for People With Developmental Disability (OPWDD) Corp ID:	
Office of Children and Family Services (OCFS) Agency ID:	
Department of Health (DOH) ACF or Camp ID:	
State Education Department (SED) Provider ID (aka BEDS Code) :	8000000
Office of Alcoholism and Substance Abuse Services (OASAS) Provider ID:	

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