

1. DATE OF SUBMISSION	State of New York OFFICE FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES
2. APPLICANT NAME	
Request for MHL §16.34 ABUSE/NEGLECT HISTORY CHECK	
3. APPLICANT SSN	
4. APPLICANT DOB	
5. AUTHORIZED PERSON NAME	
6. AUTHORIZED PERSON EMAIL ADDRESS	
7. PROVIDER OF SERVICES NAME	
8. IS THE PROVIDER A REGISTERED PROVIDER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <i>(note that Registered Providers are required to submit requests for MHL 16.34 checks)</i>	
9. PROGRAM TYPE (select four digit code from page 2) _____ (same as listed on CBC request)	
10. APPLICANT IS: 1 <input type="checkbox"/> Prospective Employee 2 <input type="checkbox"/> Prospective Volunteer	
11. WAS AN SEL REQUEST SUBMITTED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
12. WAS A CBC REQUEST SUBMITTED, OR WILL ONE BE SUBMITTED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
<p><u>INSTRUCTIONS:</u></p> <p>This form must be submitted to OPWDD for <u>all</u> prospective employees and volunteers in the OPWDD system. The form must be submitted by all certified and non-certified programs and registered providers.</p> <p>The purpose of this form is to request that OPWDD conduct a check of records of substantiated allegations of abuse and neglect that occurred or were discovered prior to June 30, 2013 and that involved the applicant. This supplements the check of the “Staff Exclusion List” (SEL) requested from the Justice Center which concerns substantiated abuse and neglect that occurred on or after June 30, 2013.</p>	

This form may only be submitted by “authorized persons.” Authorized persons are individuals who are currently authorized by providers of services (including registered providers) to request criminal history record checks from the Justice Center, pursuant to Section 845-b of the Executive Law.

Only providers of services in the OPWDD system may submit this form.

This form should not be used to screen multiple applicants for a position; it should only be submitted for an applicant whom the agency intends to hire or accept as a volunteer based on the information provided.

This form is submitted only after the authorized person receives results of the check of the Staff Exclusion List (SEL) from the Justice Center. If the provider is barred from hiring the applicant or has decided not to hire the applicant for any reason after the SEL check, the provider should not submit this form.

This form is only submitted for applicants when the authorized person is also submitting a Criminal Background Check (CBC) request for an applicant. This form may be submitted to OPWDD at the same time the CBC request is submitted to the Justice Center; it is not necessary for the authorized person to wait for the results of the CBC check. The form may also be submitted at the same time a check of the Statewide Central Register of Child Abuse and Maltreatment is requested.

This form is only submitted for applicants who are prospective employees or volunteers. The definition of “employee” is found in 14 NYCRR Section 633.22.

This form must be submitted in a secure manner together with a form completed by the applicant (OPWDD-152 Applicant information). The forms are submitted securely via email to: ojr@opwdd.ny.gov.

The authorized person should compare the completed OPWDD-152 with other information provided by the applicant during the application process to make sure that the information is consistent.

Pursuant to OPWDD regulations, the applicant is not allowed to have unsupervised contact with individuals receiving services until the results of the MHL 16.34 check are received.

Results will be sent to the authorized person at the email address provided. OPWDD will make every effort to send results as soon as possible. However, if the applicant has prior employment or volunteer work in the OPWDD system it may take several weeks.

OPWDD will inform the authorized person whether there is any history of substantiated abuse or serious neglect of which it is aware that can be disclosed. In the event that there is relevant history, OPWDD will provide a summary report of the substantiated allegation. In the event that such information is provided, the agency is required to review the information provided and to make a decision about whether to hire or otherwise allow the party to have regular and substantial contact with an individual receiving services. Such decision and the rationale for the decision shall be documented. OPWDD will also inform the authorized person if it is not aware of any abuse/neglect history that can be disclosed.

In the event that the authorized person becomes aware that the applicant is no longer under consideration or has separated from service before the authorized person has received notification of the results, please notify OPWDD so that it may discontinue the check. In this event, send a request to discontinue the check via secure email to the same mailbox with the applicant’s name, SSN and date of submission of the original request.

There is no charge for MHL 16.34 checks.

PROGRAM CODE	PROGRAM NAME
0053	Community Residence Part 671 – Residential Habilitation
0060	Crisis Intervention
0070	Summer Camp
0080	Residential School
0090	Intermediate Care Facility (30 beds or less)
0091	TUBS – Intermediate Care Facility (30 beds or less)
0100	Clinic Treatment Facility (Free-Standing Clinic)
0101	Clinic Treatment Facility (Clinic Joint Venture)
0120	Specialty Clinic
0150	Family Support Services
0190	Program Development Grants
0200	Day Treatment
0202	Day Treatment Partial
0212	HCBS Day Habilitation Service
0213	HCBS Prevocational Services
0214	HCBS Supported Employment
0215	HCBS Environmental Modifications
0216	HCBS Adaptive Technologies
0219	HCBS Residential Habilitation Service (At home)
0220	HCBS Residential Habilitation Service (Family Care)
0221	HCBS Assistive Supports
0222	Other Service Coordination (Non-Medicaid)
0229	Medicaid Service Coordination (MSC)
0231	HCBS Supervised IRA (Room & Board & Residential Habitation Services)
0232	HCBS Supportive IRA (Room & Board & Residential Habitation Services)
0233	HCBS Freestanding Respite
0235	HCBS Hourly Respite
0330	Day Training
0340	Sheltered Workshop/Certified Work Activity
0360	Classroom Education
0370	Preschool Program
0380	Transitional Employment Placement
0390	Supported Employment (non-HCBS waiver)
0400	Prevocational (non-HCBS waiver)
0410	Individualized Support Services
0411	HCBS Consolidated Supports and Services
0413	HCBS Family Education and Training
0414	Epilepsy Services
0416	HCBS Waiver Plan of Care Support Services
0610	Recreation
0630	Homemaker/Housekeeping Services
0650	Respite Care
0670	Transportation
0750	Information and Referral
0810	Case Management
0880	Subcontract Service
0890	Local Governmental Unit (LGU) Administration
1053	Community Residence Part 671 Supportive –Residential Habitation
1090	Intermediate Care Facility (over 30 beds)
1150	Traumatic Brain Injury (TBI)
1190	Special Legislative Grants
1220	HCBS Care at Home –III
1670	Integrated Employment Transportation
1850	Voluntary Preservation Project
2090	VOICF/DD, Sheltered Workshop
2091	VOICF/DD, Sheltered Workshop (not operated by service provider)
2190	Developmental Disabilities Program Council Grants
2220	HCBS Care at Home – IV &VI
3070	Shelter Plus Care Housing
3090	VOICF/DD, School District Contract
4090	SOICF Sheltered Workshop/Day Training
5090	VOICF/DD Day Training
5091	VOICF/DD Day Training (not operated by a service provider)
6090	Day Program Service Included in ICF/DD (On-site)
6091	Day Program Services Included in ICF/DD (Off-site)