**Background Submission Coversheet for Authorized Providers**

|  |  |
| --- | --- |
| **Agency:** | **Date:** |
| **Address:** | **Organization Contact:** |
| **City/State/ZIP:** | **Email:** |
| **Phone:** |  |

The applicant(s) below applied for employment with a Wyoming Department of Health direct care facility, the Medicaid Home and Community Based Services (HCBS) Developmental Disability Waiver program, or other Wyoming Department of Health service with access to vulnerable populations or personally identifiable information and that require a state or national criminal history review.

**Fingerprints SS-26 Agent Applicant Name**

**Note: Both fingerprints and the SS-26 Agent form are required for a WDH direct care facility, the HCBS, and Public Health programs. WDH processes the Notice of Results following receipt of both fingerprints and SS-26.**

**Payment**

|  |  |  |
| --- | --- | --- |
| **Account Name/Money Order** | **Check Number** | **Amount** |
|  |  |  |
|  |  |  |

**Invoice**

|  |  |  |
| --- | --- | --- |
| **Account Name** | **Account Number** | **Amount** |
|  |  |  |

**Submit this document and accompanying attachments to the address below.**