Wyoming Department of Health

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Michael A. Ceballos
Director

Mark Gordon
Governor

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
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☐	☐	
☐	☐	
☐	☐	
☐	☐	
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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.

Wyoming Department of Health
Background Systems Specialist
2300 Capitol Ave. – 4th Floor
Cheyenne, WY 82002