**Background Submission Coversheet for Self-Directed Care Providers**

*Use this form if you are employed directly by the DD Waiver participant or their guardian*

|  |  |
| --- | --- |
| **DD Waiver Participant:** | **Date:** |
| **Employer of Record:** | **Address:** |
| **Email:** | **City/State/ZIP:** |
| **Phone:** |  |

Check this box if one or more applicants is not a service provider, but is an adult living in a provider’s home where services are provided. List those individuals here:

The applicant(s) below applied for employment with the Medicaid Home and Community Based Services (HCBS) Developmental Disability Waiver program, providing services to a DD Waiver participant who has opted for self-directed care.

**Fingerprints SS-26 Agent Applicant Name**

**Note: Both fingerprints and the SS-26 Agent form are required for the HCBS waiver programs. WDH processes the Notice of Results following receipt of both fingerprints and SS-26. Notice of Results will also be sent to ACES$ Financial Management Services.**

**Payment**

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

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