



401 Hathaway Building • Cheyenne, WY 82002
 Phone (307) 777-7656 • 1-866-571-0944
 Fax (307) 777-7439 • www.health.wyo.gov



Michael A. Ceballos
 Director

Mark Gordon
 Governor

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:
Employer of Record:
Email:
Phone:

Date:
Address:
City/State/ZIP:

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
<input type="checkbox"/>	<input type="checkbox"/>	

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.