**Background Submission Cover Sheet**

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| **EOR/ACES$/Agency****:** |  | **Date:** |  |
| **Address:** |  | **Contact:** |  |
| **City/State/ZIP:** |  | **Email:** |  |
| **Phone:** |  |  |  |

The applicant below has 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.

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| --- | --- | --- | --- | --- |
| **Fingerprint Card & Applicant Name** | | **Phone & E-Mail** | **Date of Birth** | **Social**  **Security #** |
|  |  |  |  |  |

**Note: Two fingerprint cards and payment of $49 is required for the applicant listed above.**

**Payment**

|  |  |  |
| --- | --- | --- |
| **Money Order** | **Check Number** | **Amount** |
|  |  |  |

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