**Background Submission Cover Sheet**

 **Name of employer/**

|  |  |  |  |
| --- | --- | --- | --- |
| **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.

|  |  |  |  |
| --- | --- | --- | --- |
| **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.**

**AUTHORIZATION OF RELEASE OF CRIMINAL BACKGROUND INFORMATION:**

**I HEREBY AUTHORIZE THE WYOMING DEPARTMENT OF HEALTH TO CONDUCT A BACKGROUND INFORMATION CHECK THROUGH THE DIVISION OF CRIMINAL INVESTIGATION, THE FEDERAL BUREAU OF INVESTIGATION AND THE DEPARTMENT OF FAMILY SERVICES (DFS) AND SEND THE RESULTS TO THE HIRING AGENCY. I AGREE TO PROVIDE THE FOLLOWING INFORMATION AND ANY OTHER INFORMATION NEEDED TO INITIATE THE BACKGROUND CHECK. I UNDERSTAND THAT MY FALSIFICATION OF INFORMATION OF FINDINGS OF SUBSTANTIATED CRIMINAL OR ABUSE ACTIVITIES MAY BE GROUNDS FOR TERMINATION OF EMPLOYMENTS**

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 APPLICANT SIGNATURE DATE