DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01246 (02/2017)

STATE OF WISCONSIN
Wisconsin Statutes
§ 48.685 and 50.065
Administrative Rule
DHS 12.05(4)

BACKGROUND INFORMATION DISCLOSURE ADDENDUM—IRIS

INSTRUCTIONS: Completion of this form is required under the provisions of Chapters 48.685 and 50.065 Wis. Stats. Failure to comply may result in a denial or termination of your employment.

Personally identifiable information on this form is collected to verify your identity and that the form is complete.

SECTION I – APPLICANT INFORMATION

Name – (Last, First, MI)	Date of Birth / /

Please list all the cities and states in which you have lived in the past three years, and the name by which you were known (if different from your name now). Please indicate the number of years you lived there.

Address – (Address, City, State, Zip Code)	Years at Residence	Any Other Names By Which You Have Been Known (Including Maiden Name)

SECTION II – ADDITIONAL APPLICANT INFORMATION

Completion of this section is only required for applicants who have lived outside the state of Wisconsin in the past three years.

Current Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County
Previous Address	City	State	Zip Code	County

Mother's Maiden Name	Mother's Current Name – (Last, First, MI)

Father's Name – (Last, First, MI)

I acknowledge that the information on this form is accurate to the best of my knowledge. By signing below, I agree to have a background check run.

I further acknowledge that an out-of-state background check may increase processing time, if applicable.

SIGNATURE – Applicant	Date Signed