Home and Community Based Services

Employment-related Personal Assistance Services (EPAS)

**Application**

**Personal Information** Please send initial paperwork to me [ ]

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |       | Date of Application: |       |
| Birth Date: |       | Gender: Male [ ]  Female [ ]  |
| Address: |        | City: |       | Zip Code: |       |
| Social Security Number: |       | County of Residence: |       |
| Phone Number: |       | Other Phone: |       |
| Email Address: |       | Have you applied for EPAS before? Yes [ ]  No [ ]  |

**Legal Guardian Information** Please send initial paperwork to my guardian [ ]

|  |
| --- |
| Do you have a legal guardian to help you with the EPAS application process? Yes [ ]  No [ ]  If you selected yes, please fill out the information below. |
| Name of Legal Guardian: |       | Relation: |       |
| Address:  |        | City, State: |       | Zip Code: |       |
| Email Address: |       | Phone Number: |       |

**Proxy or Agency Information**  Please send initial paperwork to my proxy [ ]

|  |
| --- |
| Do you have a proxy or agency to help you with the EPAS application process? Yes [ ]  No [ ]  If you selected yes, please fill out the information below. |
| Name of Proxy:  |       | Phone Number: |       |
| Relation, if applicable: |       | Email: |       |
| Address: |       | City, State |       | Zip Code: |       |

**EPAS Qualifications**

|  |
| --- |
| In order to qualify for the EPAS program you must meet the criteria below. |
| Do you receive Utah Medicaid? Yes [ ]  No [ ] Are you currently employed or have a job offer? Yes [ ]  No [ ]  Do you work a minimum of 40 hours per month?  Yes [ ]  No [ ]   | Do you have a disability? Yes [ ]  No [ ]  Describe your disability: |
|  |       |  |
|  |       |  |
|  |       |  |
| **Office Use Only** |
| Date application received: |  | Case #: |  | Medicaid ID#: |  |
| Medicaid Type / Category: |  | MWI Premium Amount: |  | DWS Review Date: |  |
|  |  |  |  |  |  |

**Please Attach copy of your Paystub, Earnings Statement, *or* \*\*Letter from your Employer.**

**Your application will not be accepted without this attachment.**

**Signatures-6955all: ation & Employment Informational Assistant is only assisting with teh ll. for IADLs. ency.Employment Information \***

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employer: |       | Phone: |       |
| Address:  |       | City: |       | Zip Code: |       |
| Supervisor’s Name: |       | Date you Started Working: |       |
| Job Title: |       | Job Description: |       |
| Hours worked each **week**:  |       | Select the days of the week you work: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Sun Mon Tue Wed Thu Fri Sat | What is your Rate of Pay? |
| Hours worked each **month**: |       |  | $  |       | per hour/salary |
| **\*Please fill out page 5 if you are Self-Employed \*\* See page 4 for Letter Template** |
|  **Services**  |
| How did you find out about EPAS? |       |
| Are you Receiving Services from Any of These Agencies? |
| [ ]  Vocational Rehabilitation[ ]  Social Security Administration[ ]  Department of Workforce Services[ ]  Services for People with Disabilities (DSPD)[ ]  Independent Living Center[ ]  Mental Health Agency | [ ]  School District[ ]  Work Incentive Planning Services (UWIPS)[ ]  Medicare[ ]  Home Health Agency:     [ ]  Provider Agency:     [ ]  Other:      |
| What Personal Assistant Services do you Need in order to Maintain your Employment? |
| [ ]  Mobility in Bed[ ]  Transferring[ ]  Ambulation[ ]  Dressing, Upper and/or Lower Body[ ]  Eating[ ]  Toilet Use/Incontinence Care[ ]  Personal Hygiene[ ]  Bathing | [ ]  Meal Preparation and/or Cooking[ ]  Housekeeping[ ]  Laundry[ ]  Managing Finances[ ]  Shopping[ ]  Transportation to work[ ]  Reminders[ ]  Other:       |

**Personal Assistant(s)**

|  |  |  |
| --- | --- | --- |
| Individuals hired to be Personal Assistants may include: | * Parents/Guardians

 (If you are over the age of 18) | * Family members, Siblings
 |
| * Neighbors, Friends
 | * Others hired through an ad
 |
| Do you have anyone in mind to be your Personal Assistant?  | Yes [ ]  No [ ]   |
| If you answered yes, who: |       |

**How to Submit EPAS Application & Personal Employment Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
|  |  |  |  |  | Utah Department of Health |
| Email: | asolovi@utah.gov |  |  |  | Division of Medicaid & Health Financing |
| Fax:  | (801) 323-1588 |  | or Mail to: |  | Attn: EPAS |
| For Questions call:  | (801) 538-6955 |  |  |  | PO Box 143112 |
|  |  |  |  |  | Salt Lake City, UT 84114 |

**Signatures**

The information written on this form is correct to the best of my knowledge and is furnished as a condition of my eligibility for Employment-related Personal Assistant Services. I authorize any person or organization the ability to release information with regards to this form to the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization & Community Based Services or its designee.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |       |  |       |  |
|  | EPAS Applicant Signature |  | Date |  |
|  |       |  |       |  |
|  | \*EPAS Representative Signature, if applicable |  | Date |  |
|  |       |  |
|  | \*Relationship to EPAS Participant including any legal authority |  |

Home and Community Based Services

Employment-related Personal Assistance Services (EPAS)

**Letter of Employment**

|  |
| --- |
|       |
| *(Name of Company)* |
|       |
| *(Address)* |
|       |
| *(City, State Zip)* |

|  |
| --- |
|       |
| *(Date)* |

Utah Department of Health

Division of Medicaid & Health Financing

PO Box 143112

Salt Lake City, UT 84114-3112

Dear EPAS Specialist,

|  |  |  |  |
| --- | --- | --- | --- |
|       | began (or will begin) working for |       | at/on |
| *(Name of Employee/EPAS Participant)* |  | *(Name of Company)* |  |
|      . | The title of his/her position is |       | A description of their duties |
| *( Start Date)* |  | *(Title of Position)* |  |
| includes: |      . | His/ Her rate of pay is | $     . |
|  | *(Description of Duties)* |  | *(Hour or salary)* |
| It is anticipated that he/she will work a total of |       | hours per week.  |
|  | *(Hours worked)* |  |

I certify that the above information is correct to the best of my knowledge. I also acknowledge that this letter will be used for verification purposes to determine employment for the EPAS participant listed above.

Sincerely,

|  |
| --- |
|       |
| Name |
|  |
| Position in Company |
|  |
| Direct Phone Number |

**Please attach a copy of your Business License issued by the State of Utah or local municipality *and* your Federal tax return statement from the most current year.**

**Your application will not be accepted without these attachments.**

**Self-Employment Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Business: |       | Business Phone: |       |
| Business Address:  |       | City: |       | Zip Code: |       |
| Number of Employees: |       | Product or Service Offered:  |       |
| Description of Business: |       |
| Hours worked each **week**:      Hours worked each **month**:      What is your **Net Income** each month? $      What is your **Gross Income** each month? $       | Select the days of the week your business is open: [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  [ ]  Sun Mon Tue Wed Thu Fri Sat  |
| Please select what stage your business is in:1) [ ]  Business planning stageIf you selected number one, please indicate the date in which you plan to begin your business:      2) [ ]  Business start-up stageIf you selected number two, please indicate the date in which your business began:      3) [ ]  Business operations stageIf you selected number three, please indicate how long you have been in business:     Business begin date:      |