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](mailto: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 stage  If you selected number one, please indicate the date in which you plan to begin your business:  2)  Business start-up stage  If you selected number two, please indicate the date in which your business began:  3)  Business operations stage  If you selected number three, please indicate how long you have been in business:  Business begin date: | | | | | | | |