Home and Community Based Services

Employment-related Personal Assistant Services (EPAS)

**Disenrollment Request Form**

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| **Program:** | Employment-related Personal Assistant Services (EPAS) | |
| **Program Contact:** | EPAS Program Specialist  Phone: (801) 538-6955  Fax: (801) 323-1588 | Utah Department of Health  Division of Medicaid & Health Financing  PO Box 143112  Salt Lake City, UT 84114 |

**To Be Completed By Service Coordinating Agency:**

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| **Participant Name:** |  | **Medicaid ID:** |  |
| **Phone Number:** |  | **Date of Birth:** |  |
| **Address:** |  | **Representative, if applicable:** |  |
| **Relationship to participant:** |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Service Coordinating Agency:** |  | **Name:** |  | |
| **Phone:** |  | |
| **Email:** |  | |
| **Date of Enrollment:** |  | **Recommended Date of Disenrollment:** | |  |

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| **The EPAS Participant’s chosen Service Coordinating Agency is recommending disenrollment from the EPAS program for the following reason(s):** | | | |
| Participant voluntarily choses to disenroll  (Must attach letter from participant) | |  | |
| Participant moved out of State and DWS has verified the participant is no longer eligible for Medicaid | |  | |
| Participant Death | |  | |
| Participant has been determined ineligible for Medicaid by the Division of Workforce Services for 90 days (i.e. MWI or Spendowns not paid, review not submitted) | |  | |
| Participant was unable to resume employment after 60 days. There is no reasonable expectation of continuing employment. | |  | |
| Participant has transitioned to a 1915(c) HCBS Waiver Program where Personal Care Services are provided | |  | |
| Participant, whether self-employed or employed by others, is not meeting the EPAS employment requirements. | |  | |
| Participant’s whereabouts are unknown or unable to contact for at least 30 days. | | |  |
| Participant has not utilized EPAS services for 60 days or more (i.e. Did not hire a Personal Assistant) | | |  |
| Participant is noncompliant with the Care Plan and/or program regulations | | |  |
| Fraud and/or misuse of Medicaid funds | | |  |
| Other: |  | | |

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| **Attachment Requirements** |
| Attach log notes, correspondence, or other documentation that supports discharge rationale:   * If participant is voluntarily disenrolling, a document signed by the participant or legal representative indicating their desire to disenroll from EPAS must be included. * Describe interventions made to rectify the situation, if applicable. * Describe discharge plan and coordination in place to assure participant is educated on other services that may be available to accommodate their needs (i.e. Home health, 1915 (c) waivers) |

**To be Completed by EPAS Specialist:**

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| **Requirements** | **Met** | **Not Met** | **N/A** |
| Documentation supports the discharge rationale |  |  |  |
| Interventions to rectify the situation were implemented |  |  |  |
| Adequate discharge planning and coordination is in place |  |  |  |

**Medicaid will proceed with the following disenrollment activities:**

* **Provide the participant with a decision notice, if applicable**
* **Provide the participant with informed rights to appeal form, if applicable**
* **Notify participant’s selected provider agencies of effective date of disenrollment (Service Coordinating Agencies, Financial Management Agencies, Personal Care Agencies, and EPAS Assessors)**

**Medicaid will not proceed with disenrollment.**

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| **Comments/Rationale:** |
| Click here to enter text. |

**The Division of Medicaid and Health Financing, Bureau of Authorization and Community Based Services (BACBS), with this recommendation based upon the information given above:**

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|  | EPAS Program Specialist Signature |  | Date |  |