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 SpecialistPhone: (801) 538-6955Fax: (801) 323-1588 | Utah Department of HealthDivision of Medicaid & Health FinancingPO Box 143112Salt 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:** |       |

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| **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)
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**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 |  |