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| **Applicant Name:** | |  | | | |  | **Medicaid Member ID:** | | |  | | |  |
| **Please Select One:**  I am selecting providers for the first time.  I am changing providers\* | | | | | | | **County of Residence:** | | |  | | |  |
|  | | |  | | | |
| **\*Please Complete Only if Changing Providers:** | | | | | | | | | | | | | |
| **Current Provider (s):** | | | Service Coordinating Agency: | | | |  | | | | | | |
| Financial Management Agency: | | | |  | | | | | | |
| EPAS Assessor: | | | |  | | | | | | |
| Personal Care Agency: | | | |  | | | | | | |
| I have been informed and given the opportunity to select the agency(s) below as my service providers for the Employment-related Personal Assistant Services (EPAS) program. My choice has been made independently with no prompting, encouragement, or endorsement by the Service Coordinating Agency, Financial Management Agency, EPAS Assessor, Personal Care Agency, or EPAS Specialist. I understand that I have the right to choose the provider of service(s) when more than one provider is available to render that service.  I understand that I have the right to appeal if I am denied my choice of service providers or if I am denied services that I believe I am eligible to receive.  If I have any questions about the EPAS Service Providers I know I can contact the provider or the EPAS Program Specialist at (801) 538-6955.  I understand that I may change my EPAS Service Providers at any time and for any reason. I understand my choices available, and I freely choose EPAS Services through: | | | | | | | | | | | | | |
| **Service Coordinating Agencies** | | | | **Financial Management Agencies** | | | **EPAS Assessors** | | | | **Personal Care Agencies** | | |
| HOPE Services | | | | Acumen Fiscal Agent | | | Hillary Bemel L.C.S.W. | | | | Home Instead | | |
|  | | | | Premier FMS  Morning Sun | | | Utah Case Management | | | | Caregiving Services | | |
|  | | | |  | | |  | | | | Rocky Mountain Personal Care | | |
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|  |  | | | |  | | |  |  | | |  | |
|  | EPAS Participant’s Signature | | | |  | | |  | Date | | |  | |
|  |  | | | |  | | |  |  | | |  | |
|  | \*EPAS Representative’s Signature, if applicable | | | |  | | |  | Date | | |  | |
|  |  | | | | | | | | | | |  | |
|  | \*Relationship to EPAS Participant including any legal authority | | | | | | | | | | |  | |
|  |  | | | |  | | |  |  | | |  | |
|  | EPAS Specialist’s Signature | | | |  | | |  | Date | | |  | |
|  | | | | | | | | | | | | | |