Home and Community Based Services

Employment-related Personal Assistance Services (EPAS)

**Participant Information Form**

|  |  |  |  |
| --- | --- | --- | --- |
| Date of Interview: |       | DWS Review Date: |       |
| Next Care Plan Renewal Date: |       | Next MDS-HC Renewal Date: |       |
| Original EPAS Enrollment Date : |       |

**EPAS Participant Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |       | Date of Birth: |       | Medicaid ID: |       |
| Gender:  | Select One | Select Phone |       | Other Phone: |       |
| Physical Address: |       | City: |       | Zip Code: |       |
| Mailing Address: |       | City: |       | Zip Code: |       |
| Type of Residence: | Select One | County of Residence: | Select One |
| Email Address: |       |
| Medical Diagnosis: |       | Description of Disability: |       |

**Guardian or Representative Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Name: |       |  Select Phone |       | Other Phone: |       |
| Relationship to Participant: |       | Description of Legal Authority to act on their behalf, if applicable: |       |
| Physical Address: |       | City: |       | Zip Code: |       |
| Mailing Address:: |       | City: |       | Zip Code: |       |
| Email Address |       |

**Provider Agency Information**

|  |  |
| --- | --- |
| Service Coordinating Agency: | Select One |
|  | Name: |       |
| Email: |       |
| Phone: |       |
| EPAS Assessor: | Select One |
|  | Name: |       |
| Email: |       |
| Phone: |       |
| Financial Management Agency: | Select One |
|  | Name: |       |
| Email: |       |
| Phone: |       |
| Personal Care Agency: |  |
|  | Name: |       |
| Email: |       |
| Phone: |       |

**SAS Employees\***

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employee #1: |       | Select Phone |       |
| Relationship to EPAS Participant: |       | Agreed Upon Rate of pay |       |
| FMS Agency Hire Date: |       | Signed Employer/Employee Agreement: | Select One |
| Email : |       | Address : |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employee #2: |       | Select Phone |       |
| Relationship to EPAS Participant: |       | Agreed Upon Rate of pay |       |
| FMS Agency Hire Date: |       | Signed Employer/Employee Agreement:  | Select One |
| Email : |       | Address : |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employee #3: |       | Select Phone |       |
| Relationship to EPAS Participant: |       | Agreed Upon Rate of pay |       |
| FMS Agency Hire Date: |       | Signed Employer/Employee Agreement:  | Select One |
| Email : |       | Address : |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employee #4: |       | Select Phone |       |
| Relationship to EPAS Participant: |       | Agreed Upon Rate of pay |       |
| FMS Agency Hire Date: |       | Signed Employer/Employee Agreement:  | Select One |
| Email :  |       | Address : |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Employee #5: |       | Select Phone |       |
| Relationship to EPAS Participant: |       | Agreed Upon Rate of pay |       |
| FMS Agency Hire Date: |       | Signed Employer/Employee Agreement:  | Select One |
| Email : |       | Address :  |       |

\* If participant has more than five SAS Personal Assistants, please attach “Participant Information Form-Additional SAS Employees.”

**Self-Employment**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Business #1: |       | Business License: |       |
| Business Phone: |       | Number of Employees: |       |
| Business Address |       | City |       | Zip Code: |       |
| Product or Service Offered: |       | Description of Business: |       |
| Hours worked each week: |       | Hours worked each month: |       | Average Monthly Wage: |       |

**Self-Employment Work Schedule**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Mon** | **Tues** | **Wed** | **Thurs** | **Fri** | **Sat** | **Sun** |
| **Morning** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Afternoon** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Evening** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Notes:** |
| Click here to enter text. |

**Employed By Others\***

|  |  |  |  |
| --- | --- | --- | --- |
| Employer’s Name #1 |       | Name of Supervisor: |       |
| Employer’s Address |       | City |       | Zip Code: |       |
| Employer’s Phone: |       | Job Start Date: |       |
| Hours worked per week: |       | Hours worked per month: |       |
| Job Title:  |       | Job Description: |       |

|  |  |  |  |
| --- | --- | --- | --- |
| Employer’s Name #2 |       | Name of Supervisor: |       |
| Employer’s Address |       | City |       | Zip Code: |       |
| Employer’s Phone: |       | Job Start Date: |       |
| Hours worked per week: |       | Hours worked per month: |       |
| Job Title:  |       | Job Description: |       |

\* If participant has more than two places of employment, please attach “Participant Information Form-Additional Employment.”

**Employed By Others Work Schedule**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Mon** | **Tues** | **Wed** | **Thurs** | **Fri** | **Sat** | **Sun** |
| **Morning** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Afternoon** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Evening** | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  | **[ ]**  |
| **Notes:** |
| Click here to enter text. |

**Additional Information:**

|  |
| --- |
| Describe other supports are being utilized by participant? (Reflected on Other Supports on Care Plan) |
| [ ]  Natural Supports at Home | [ ]  Subsidized Housing | [ ]  Supplemental Security Income (SSI) |
| [ ]  Natural Supports at Work | [ ]  Mental or Behavioral Health Services | [ ]  Social Security Disability Insurance (SSDI) |
| [ ]  Voc Rehab or Job Coach | [ ]  Division of Services for People with Disabilities (DSPD) Program | [ ]  Benefit Planning |
| [ ]  Home Health Services | [ ]  Food Stamps or Food Assistance |  |
| Other: (i.e. other Medicaid or Medicare benefits, personal care services, waiver program) |
| Click here to enter text. |
| Strengths/Goals of Participant: |
| Click here to enter text. |
| Care Plan or MDS-HC Changes: (i.e. Did client’s needs increase or decrease from the previous year that affected their employment?) |
| Click here to enter text. |
| Additional Notes: |
| Click here to enter text. |

**Care Plan Renewal Checklist:**

|  |  |
| --- | --- |
| **Forms to Submit:** | **Other Items:** |
| [ ]  Care Plan | [ ]  Participant’s Home is a safe environment for services to be rendered. |
| [ ]  Program Participation Form  | [ ]  EPAS Participant is able to Self-Administer Services appropriately and manage Employees, if applicable |
| [ ]  Employer/Employee Agreement from each SAS Employee, if applicable | [ ]  Capture any updates to information i.e. phone numbers, place of employment |
| [ ]  Freedom of Choice Form, if applicable | [ ]  Remind participant of DWS Review date, and to updated DWS of any Address, Phone, Employment, or Income updates.  |
| [ ]  Employment Verification (See Section 8 of EPAS Manual for requirements)  | [ ]  Participant was visited in the home face-to-face. |