

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 <input type="checkbox"/>	Female <input type="checkbox"/>
Address:	City:		Zip Code:
Social Security #:		County of Residence:	
Phone Number:		Other Phone:	
Email Address:		Have you applied for EPAS before? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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 <input type="checkbox"/> No <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/>			
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 <input type="checkbox"/> No <input type="checkbox"/>	Do you have a disability? Yes <input type="checkbox"/> No <input type="checkbox"/>
	Describe your disability:

Are you currently employed or have a job offer?

Yes No

Do you work a minimum of 40 hours per month?

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.

Employment Information *

Name of Employer:		Phone:	
Address:		City:	
Supervisor's Name:		Date you Started Working:	
Job Title:		Job Description:	
Hours worked each week:		Select the days of the week you work:	
Hours worked each month:		<input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat	
		What is your Rate of Pay?	
		\$ _____ per hour/ salary	

*Please fill out page 5 if you are Self-Employed Template

** See page 4 for Letter

Services

How did you find out about EPAS? _____	
Are you Receiving Services from Any of These Agencies?	
<input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Social Security Administration <input type="checkbox"/> Department of Workforce Services <input type="checkbox"/> Services for People with Disabilities (DSPD) <input type="checkbox"/> Independent Living Center <input type="checkbox"/> Mental Health Agency	<input type="checkbox"/> School District <input type="checkbox"/> Work Incentive Planning Services (UWIPS) <input type="checkbox"/> Medicare <input type="checkbox"/> Home Health Agency: _____ <input type="checkbox"/> Provider Agency: _____ <input type="checkbox"/> Other: _____

What Personal Assistant Services do you Need in order to Maintain your Employment?	
<input type="checkbox"/> Mobility in Bed <input type="checkbox"/> Transferring <input type="checkbox"/> Ambulation <input type="checkbox"/> Dressing, Upper and/or Lower Body <input type="checkbox"/> Eating <input type="checkbox"/> Toilet Use/Incontinence Care <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Bathing	<input type="checkbox"/> Meal Preparation and/or Cooking <input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Managing Finances <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation to work <input type="checkbox"/> Reminders <input type="checkbox"/> Other: _____

Personal Assistant(s)

Individuals hired to be Personal Assistants may include:	<ul style="list-style-type: none"> ▪ Parents/Guardians (If you are over the age of 18) ▪ Neighbors, Friends ▪ Family members, Siblings ▪ Others hired through an ad
Do you have anyone in mind to be your Personal Assistant?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If you answered yes, who:	_____

How to Submit EPAS Application & Personal Employment Information

Email: EPAS@utah.gov Fax: (801) 323-1588 For Questions call: (801) 538-6955	or Mail to:	Utah Department of Health & Human Services Division of Integrated Healthcare Attn: EPAS PO Box 143112 Salt Lake City, UT 84114
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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 and Human Services, Division of Integrated Healthcare, Office of Long Term Services and Supports, 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) (Date)

 (Address)

 (City, State Zip)

Utah Department of Health & Human Services
 Division of Integrated Healthcare
 PO Box 143112
 Salt Lake City, UT 84114-3112

Dear EPAS Specialist,

_____ began (or will begin) working _____ at/on
 for _____
 (Name of Employee/EPAS Participant) (Name of Company)

_____ The title of his/her position _____ A description of their duties
 is _____
 (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 _____ hours per week.
 of _____
 (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

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 : _____	Select the days of the week your business is open: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sun Mon Tue Wed Thu Fri Sat		
Hours worked each month : _____			
What is your Net Income each month? \$_____			
What is your Gross Income each month? \$_____			
Please select what stage your business is in: 1) <input type="checkbox"/> Business planning stage If you selected number one, please indicate the date in which you plan to begin your business: 2) <input type="checkbox"/> Business start-up stage If you selected number two, please indicate the date in which your business began: 3) <input type="checkbox"/> Business operations stage If you selected number three, please indicate how long you have been in business: Business begin date:			