Utah Department of
Health & Human Services
Integrated Healthcare

Home and Community-Based Services
Employment-related Personal Assistant Services (EPAS)

Disenrollment Request Form

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:

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:		

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:	

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:

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.

Comments/Rationale:
Click here to enter text.

The Division of Integrated Healthcare, Office of Long Term Services and Supports, concurs with this recommendation based upon the information given above:

EPAS Program Specialist Signature _____ Date _____