Employment-related Personal Assistant Services (EPAS)
Freedom of Choice Consent Form
Utah County

Utah Department of Health & Human Services

Applicant Name: _____ **Please Select One:** ☐ I am selecting providers for the first time. ☐ I am changing providers*	**Medicaid Member ID:** _____ **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:

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Service Coordinating Agencies	Financial Management Agencies	EPAS Assessors	Personal Care Agencies
☐ HOPE Services	☐ Acumen Fiscal Agent	☐ Hillary Bemel L.C.S.W.	☐ 1 Assist Care
	☐ Premier FMS	☐ Utah Case Management	☐ Caregiving Services
☐ Northern Utah Case Management	☐ Morning Sun		☐ Rocky Mountain Personal Care

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 _____