

Employment-related Personal Assistant Services (EPAS)



Freedom of Choice Consent Form

Washington, Kane, Iron, Garfield & Beaver Counties

Applicant Name: _____ Please Select One: <input type="checkbox"/> I am selecting providers for the first time. <input type="checkbox"/> 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:

Employment-related Personal Assistant
Services (EPAS)



Freedom of Choice Consent Form

Washington, Kane, Iron, Garfield & Beaver Counties

Service Coordinating Agencies	Financial Management Agencies	EPAS Assessors	Personal Care Agencies
<input type="checkbox"/> Kim King N.U.C.M.	<input type="checkbox"/> Acumen Fiscal Agent <input type="checkbox"/> Premier FMS <input type="checkbox"/> Morning Sun	<input type="checkbox"/> Hillary Bemel L.C.S.W. <input type="checkbox"/> Utah Case Management	<input type="checkbox"/> At Home Care and Health Services (Washington & Iron Counties only) <input type="checkbox"/> 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