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. |