Utah Department of
Health & Human Services
Integrated Healthcare

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

SAS Employer/Employee Agreement

This agreement is between the: ______________________ and ______________________.

EPAS Participant (Employer) — Personal Assistant (Employee)

EPAS PARTICIPANT (EMPLOYER) SECTION:

The following questions must be completed by the EPAS Participant (Employer) directly.

My Personal Assistant has agreed to help me with the following services:

☐ Mobility in Bed	☐ Toilet Use	☐ Laundry
☐ Transferring	☐ Personal Hygiene	☐ Managing Finances
☐ Ambulation	☐ Bathing	☐ Grocery Shopping
☐ Dressing, Upper & Lower Body	☐ Meal Preparation	☐ Transportation*
☐ Eating	☐ Ordinary Housework	☐ Managing Medications

*** Must Provide Copy of Driver's License and Insurance if providing transportation.**

My Personal Assistant has accepted the rate of $ __________ per hour to provide the above services.

We have agreed upon the following work schedule: ______________________

PERSONAL ASSISTANT (EMPLOYEE) SECTION:

As a condition of providing services under this Agreement, the Personal Assistant (Employee) must agree to and answer the following questions listed below in this document. (Please initial).

Full Name:		Relationship to EPAS Participant, if applicable:	
Phone Number:		Financial Management Agency:	
Email :		Address :	

	I have never committed Medicaid fraud and understand that I may be required to pay back my earnings to Medicaid or be subject to criminal investigation should I be found to be committing Medicaid fraud.
	I certify that I have been trained how to deliver EPAS services according to the authorized Care Plan by the EPAS participant (Employee) and/or Representative. I also acknowledge that I may only provide and bill for services identified on the authorized Care Plan in accordance with the amount, frequency and duration specified.
	I understand I am hired at-will by the EPAS participant (Employer). Employment at-will means that the employee may quit at any time for any reason or no reason, just as the EPAS participant (Employer) may discharge the employee at any time, for any reason or no reason.
	I am 16 years of age or older. I understand that my parent must co-sign this agreement if I am under the age of 18.
	I will maintain an accurate timesheet of all services rendered. (Completing an accurate timesheet may include providing the type of service rendered, the date, and the number of services hours delivered. However, please consult with the selected Financial Management Agency how to accurately complete their timesheet).
	I understand that I am responsible to provide the services above, and that subcontracting services is prohibited.
	I understand that no payment for services will be made until the EPAS participant (Employer) reviews, signs, and submits my original timesheet.
	I understand that if I am injured while performing services to the EPAS participant (Employer) I have access to worker's compensation insurance. I acknowledge that I must contact the EPAS participant's (Employer's) Financial Management Agency and file a report with them within 24 hours. Worker's Compensation Hotlines; • Acumen Fiscal Agency: 1-866- 472-2297 • Premier Fiscal Agency: 1-801-317-1900 • Morning Star Fiscal Agency: 1-763-450-5003

Are you providing transportation to the EPAS Participant (Employer)?
☐ *Yes ☐ No

***If you have answered yes to the above question, please complete the following two questions:**

	I have provided the EPAS participant (Employer) a copy of my Driver's License and understand that I may not provide transportation to the EPAS participant (Employer) if my Driver's License is expired or nonexistent.

	Please attach a copy to this document.
	I have provided the EPAS participant (Employer) a copy of my automobile liability insurance and understand that I may not provide transportation to the EPAS participant (Employer) if my automobile liability insurance is expired or nonexistent. **Please attach a copy to this document.**

Please list any criminal offenses you have been convicted of other than a traffic violation. If you have been convicted of a criminal offense, this does not necessarily exempt you from providing services. However, the EPAS participant (Employer) must be made aware of any criminal offenses committed and determine if they would like to continue extending employment.

	I understand that if the EPAS participant (Employer) does not meet the EPAS program eligibility requirements such as: not working 40 hours per month, or remain Medicaid eligible, I may not be reimbursed for the services I provide. I understand that if I have questions or concerns about the EPAS Participant's (Employer's) Medicaid Eligibility, I can contact the EPAS Participant's (Employer's) Service Coordinator for more information.
	I understand that any overpayment I receive, regardless of fault, must be promptly repaid.
	I understand that I must be sensitive to the EPAS participant's (Employer's) rights of privacy and agree to not disclose information about the care or services given unless specifically allowed by State and Federal laws and regulations.
	I understand that if I have concerns regarding the EPAS program I may contact the EPAS participant's (Employer's) Service Coordinator or the EPAS Program Specialist

PERSONAL ASSISTANT (EMPLOYEE) SIGNATURE:

*I acknowledge that by signing this document I, the **Personal Assistant (Employee)** have read and am bound by the terms of this agreement. I understand that my failure to abide by this agreement may result in the loss of employment.*

______________________________	______________________________
Personal Assistant (Employee) Signature	Date
______________________________	______________________________
Parental/Guardian Signature, if applicable	Date

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Relationship to Personal Assistant (Employee)

EPAS PARTICIPANT (EMPLOYER) SIGNATURE:

*I acknowledge that by signing this document, I the **EPAS participant (Employer)** have read and am bound by the terms of this agreement. I understand that my Personal Assistant may not be reimbursed for anything not authorized under the Care Plan or EPAS policy.*

EPAS Participant (Employer) Signature	Date
*EPAS Representative, if applicable	Date

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*Relationship to EPAS Participant (Employer) including any legal authority