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

Voluntary Disenrollment Template

Date

Utah Department of Health
Division of Medicaid & Health Financing
Attn: EPAS
PO Box 143112
Salt Lake City, UT 84114

Dear EPAS Specialist,

I Full Name wish to voluntarily disenroll from the EPAS Program. I understand that by signing below I am requesting a discontinuation of my EPAS services and as a result my Personal Assistant(s) will no longer be paid to help me with employment-related activities. I also understand my voluntary disenrollment will not prevent me from reapplying for the program in the future.

I wish to disenroll from the EPAS program on Date for the following reasons: (EPAS Participant may free hand their response here).

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I certify that my Service Coordinator has worked with me to resolve any issues I may have had regarding the EPAS program and spoken with me about other possible resources available.

Sincerely,

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EPAS Participant Signature

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*EPAS Representative, if applicable

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*Relationship to EPAS Participant including any legal authority to act on their behalf

EPAS Participant Address 1
City,ST.Zip Code