

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

Personal Information

 Please send initial paperwork to me

Name:		Date of Application:	
Birth Date:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
Address:		City:	Zip Code:
Social Security Number:		County of Residence:	
Phone Number:		Other Phone:	
Email Address:		Have you applied for EPAS before? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Legal Guardian Information

 Please send initial paperwork to my guardian

Do you have a legal guardian to help you with the EPAS application process? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If you selected yes, please fill out the information below.			
Name of Legal Guardian:		Relation:	
Address:		City, State:	Zip Code:
Email Address:		Phone Number:	

Proxy or Agency Information

 Please send initial paperwork to my proxy

Do you have a proxy or agency to help you with the EPAS application process? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If you selected yes, please fill out the information below.			
Name of Proxy:		Phone Number:	
Relation, if applicable:		Email:	
Address:		City, State:	Zip Code:

EPAS Qualifications

In order to qualify for the EPAS program you must meet the criteria below.

Do you receive Utah Medicaid? Yes <input type="checkbox"/> No <input type="checkbox"/>	Do you have a disability? Yes <input type="checkbox"/> No <input type="checkbox"/> Describe your disability: _____ _____
Are you currently employed or have a job offer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you work a minimum of 40 hours per month? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Office Use Only

Date application received: _____	Case #: _____	Medicaid ID#: _____
Medicaid Type / Category: _____	MWI Premium Amount: _____	DWS Review Date: _____

**Please Attach copy of your Paystub, Earnings Statement, or
**Letter from your Employer.
Your application will not be accepted without this attachment.**

Employment Information *

Name of Employer:		Phone:	
Address:		City:	Zip Code:
Supervisor's Name:		Date you Started Working:	
Job Title:	Job Description:		
Hours worked each week :	Select the days of the week you work: <input type="checkbox"/> Sun <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thu <input type="checkbox"/> Fri <input type="checkbox"/> Sat	What is your Rate of Pay?	
Hours worked each month :		\$	per hour/ salary

*Please fill out page 5 if you are Self-Employed

** See page 4 for Letter Template

Services

How did you find out about EPAS?	_____
Are you Receiving Services from Any of These Agencies?	
<input type="checkbox"/> Vocational Rehabilitation <input type="checkbox"/> Social Security Administration <input type="checkbox"/> Department of Workforce Services <input type="checkbox"/> Services for People with Disabilities (DSPD) <input type="checkbox"/> Independent Living Center <input type="checkbox"/> Mental Health Agency	<input type="checkbox"/> School District <input type="checkbox"/> Work Incentive Planning Services (UWIPS) <input type="checkbox"/> Medicare <input type="checkbox"/> Home Health Agency: _____ <input type="checkbox"/> Provider Agency: _____ <input type="checkbox"/> Other: _____
What Personal Assistant Services do you Need in order to Maintain your Employment?	
<input type="checkbox"/> Mobility in Bed <input type="checkbox"/> Transferring <input type="checkbox"/> Ambulation <input type="checkbox"/> Dressing, Upper and/or Lower Body <input type="checkbox"/> Eating <input type="checkbox"/> Toilet Use/Incontinence Care <input type="checkbox"/> Personal Hygiene <input type="checkbox"/> Bathing	<input type="checkbox"/> Meal Preparation and/or Cooking <input type="checkbox"/> Housekeeping <input type="checkbox"/> Laundry <input type="checkbox"/> Managing Finances <input type="checkbox"/> Shopping <input type="checkbox"/> Transportation to work <input type="checkbox"/> Reminders <input type="checkbox"/> Other: _____

Personal Assistant(s)

Individuals hired to be Personal Assistants may include:	<ul style="list-style-type: none"> ▪ Parents/Guardians (If you are over the age of 18) ▪ Neighbors, Friends ▪ Family members, Siblings ▪ Others hired through an ad
Do you have anyone in mind to be your Personal Assistant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
If you answered yes, who:	



How to Submit EPAS Application & Personal Employment Information

Email: asolovi@utah.gov Utah Department of Health
Fax: (801) 323-1588 or Mail to: Division of Medicaid & Health Financing
For Questions call: (801) 538-6955 Attn: EPAS
PO Box 143112
Salt Lake City, UT 84114

Signatures

The information written on this form is correct to the best of my knowledge and is furnished as a condition of my eligibility for Employment-related Personal Assistant Services. I authorize any person or organization the ability to release information with regards to this form to the Utah Department of Health, Division of Medicaid and Health Financing, Bureau of Authorization & Community Based Services or its designee.

_____	_____
EPAS Applicant Signature	Date
_____	_____
*EPAS Representative Signature, if applicable	Date

*Relationship to EPAS Participant including any legal authority	



Home and Community Based Services
 Employment-related Personal Assistance Services (EPAS)
Letter of Employment

(Name of Company)

(Address)

(City, State Zip)

(Date)

Utah Department of Health
 Division of Medicaid & Health Financing
 PO Box 143112
 Salt Lake City, UT 84114-3112

Dear EPAS Specialist,

_____ began (or will begin) working for _____ at/on
(Name of Employee/EPAS Participant) *(Name of Company)*

_____ The title of his/her position is _____ A description of their duties
(Start Date) *(Title of Position)*

includes: _____ His/ Her rate of pay is \$ _____.
(Description of Duties) *(Hour or salary)*

It is anticipated that he/she will work a total of _____ hours per week.
(Hours worked)

I certify that the above information is correct to the best of my knowledge. I also acknowledge that this letter will be used for verification purposes to determine employment for the EPAS participant listed above.

Sincerely,

 Name

 Position in Company

 Direct Phone Number

Please attach a copy of your Business License issued by the State of Utah or local municipality *and* your Federal tax return statement from the most current year.

Your application will not be accepted without these attachments.

Self-Employment Information

Name of Business:		Business Phone:	
Business Address:	City:	Zip Code:	
Number of Employees:		Product or Service Offered:	
Description of Business:			
Hours worked each week : _____	Select the days of the week your business is open: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sun Mon Tue Wed Thu Fri Sat		
Hours worked each month : _____			
What is your Net Income each month? \$ _____			
What is your Gross Income each month? \$ _____			
Please select what stage your business is in:			
1) <input type="checkbox"/> Business planning stage If you selected number one, please indicate the date in which you plan to begin your business:			
2) <input type="checkbox"/> Business start-up stage If you selected number two, please indicate the date in which your business began:			
3) <input type="checkbox"/> Business operations stage If you selected number three, please indicate how long you have been in business: Business begin date:			