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 ☐ Female ☐ | |
| Address: | | City: | Zip Code: |
| Social Security Number: | | County of Residence: | |
| Phone Number: | | Other Phone: | |
| Email Address: | | Have you applied for EPAS before? Yes ☐ No ☐ | |

## 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 ☐ No ☐<br>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 ☐ No ☐<br>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 ☐ No ☐<br>Are you currently employed or have a job offer?<br>Yes ☐ No ☐<br>Do you work a minimum of 40 hours per month?<br>Yes ☐ No ☐ | Do you have a disability? Yes ☐ No ☐<br>Describe your disability:<br>____________________<br>____________________ |

**Office Use Only**

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

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**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: | What is your Rate of Pay? |
|---|---|---|---|
| Hours worked each **month**: | | ☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat | $ ____ 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?**

- ☐ Vocational Rehabilitation
- ☐ Social Security Administration
- ☐ Department of Workforce Services
- ☐ Services for People with Disabilities (DSPD)
- ☐ Independent Living Center
- ☐ Mental Health Agency
- ☐ School District
- ☐ Work Incentive Planning Services (UWIPS)
- ☐ Medicare
- ☐ Home Health Agency:_____
- ☐ Provider Agency:_____
- ☐ Other:_____

**What Personal Assistant Services do you Need in order to Maintain your Employment?**

- ☐ Mobility in Bed
- ☐ Transferring
- ☐ Ambulation
- ☐ Dressing, Upper and/or Lower Body
- ☐ Eating
- ☐ Toilet Use/Incontinence Care
- ☐ Personal Hygiene
- ☐ Bathing
- ☐ Meal Preparation and/or Cooking
- ☐ Housekeeping
- ☐ Laundry
- ☐ Managing Finances
- ☐ Shopping
- ☐ Transportation to work
- ☐ Reminders
- ☐ Other: _____

## Personal Assistant(s)

Individuals hired to be Personal Assistants may include:

- Parents/Guardians (If you are over the age of 18)
- Family members, Siblings
- Neighbors, Friends
- Others hired through an ad

| Do you have anyone in mind to be your Personal Assistant? | Yes ☐ No ☐ |
|---|---|
| If you answered yes, who: | |

## How to Submit EPAS Application & Personal Employment Information

Email: asolovi@utah.gov
Fax: (801) 323-1588
For Questions call: (801) 538-6955

or Mail to:

Utah Department of Health
Division of Medicaid & Health Financing
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

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**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**: _____

Hours worked each **month**: _____

What is your **Net Income** each month? $_____

What is your **Gross Income** each month? $_____

Select the days of the week your business is open:

☐ Sun ☐ Mon ☐ Tue ☐ Wed ☐ Thu ☐ Fri ☐ Sat

Please select what stage your business is in:

1) ☐ Business planning stage

If you selected number one, please indicate the date in which you plan to begin your business:

2) ☐ Business start-up stage

If you selected number two, please indicate the date in which your business began:

3) ☐ Business operations stage

If you selected number three, please indicate how long you have been in business:

Business begin date: