Rev 4/11

Application for Employment Personal Assistance Services (EPAS)

Name:		Date of Application:
Address:	City:	Zip Code:
Birth date:	Home phone:	Other phone:
Social Security Number:	Email address:	

Do you have a legal guardian? ☐ Yes ☐ No If yes, who? ______________________

Do you have a proxy to help you plan your EPAS services? ☐ Yes ☐ No

If yes, please list: Name ______________________
Address ______________________
____
Phone ______________ Email ______________________

Do you receive Medicaid in Utah? ☐ Yes ☐ No Do you have a disability? ☐ Yes ☐ No	
Tell us about your disability:	
Are you working or do you have a job offer? ☐ Yes ☐ No Are you self-employer? ☐ Yes ☐ No	**Office Use Only** Potentially eligible? Y N

Name of Employer:		Phone:
Address:		Supervisor:
Job duties:		Job Title:
Date you started working:	Circle the days of the week you work Sun Mon Tue Wed Thu Fri Sat	How much do you get paid? $____________ per hour $____________ salary
How many hours do you work each week? __________ How many hours do you work each month? __________	**Office Use Only** Date application received ____________ Case Number ____________ Medicaid Type ____________ Medicaid ID Number ____________	

Fax application to
(801) 323-1588

or

Mail application to:

Utah Department of Health, EPAS
288 North 1460 West
PO BOX 143112
Salt Lake City UT 84114-3112

For questions call (801) 538-6955

How did you find out about EPAS?

- ☐ Vocational Rehabilitation
- ☐ Social Security Administration
- ☐ Department of Workforce Services
- ☐ Services for People with Disabilities (DSPD)
- ☐ Independent Living Center
- ☐ Mental Health Agency
- ☐ Benefits Planning
- ☐ School District
- ☐ Relative
- ☐ Friend
- ☐ Internet
- ☐ Provider Agency: ________________________
- ☐ Other ________________________________

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
- ☐ Benefits Planning
- ☐ School District
- ☐ Home Health Agency: ___________________
- ☐ Provider Agency: _______________________
- ☐ Other: _______________________________

What personal assistance services do you need to keep your job?

- ☐ Mobility or Transfers
- ☐ Ambulation
- ☐ Getting Dressed
- ☐ Eating
- ☐ Toileting/Incontinence
- ☐ Personal Hygiene
- ☐ Bathing
- ☐ Reminders
- ☐ Meal Preparation (cooking)
- ☐ Housework
- ☐ Laundry
- ☐ Managing Finances (money)
- ☐ Medication reminders
- ☐ Shopping
- ☐ Transportation for work
- ☐ Other: _______________________________

The information on this for is correct to the best of my knowledge and is furnished as a condition of my eligibility for Employment related Personal Assistance Services. I authorize any person or organization with information regarding information on this form to release said information to the Department of Health, Division of Medicaid and Health Financing, Long Term Care Bureau or its designee.

______________________________ ______________________________

Signature of Applicant Date

______________________________ ______________________________

Signature of Legal Guardian (if applicable) Date

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