Rev 3/10

Application for
Employment Personal Assistance Services (EPAS)

Name:		Date of Application:
Address:	City:	Zip Code:
Birth date:	Home phone:	Cell phone:
Other phone:	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
(a proxy can be a friend, relative, or advocate. Please fill out an authorization form so that we may contact them about your application. Call 801-538-6165 for an Authorization to Release Information form)

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-employed? ☐ 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 ID Number_______________________	

Fax application to (801) 323-1588 or mail to: **EPAS**
PO Box 143101
Salt Lake City UT 84114

For questions call (801) 538-6165

How did you find out about EPAS?	Are you receiving services from any of these agencies?
☐ Vocational Rehabilitation	☐ Vocational Rehabilitation
☐ Social Security Administration	☐ Social Security Administration
☐ Department of Workforce Services	☐ Department of Workforce Services
☐ Services for People with Disabilities (DSPD)	☐ Services for People with Disabilities (DSPD)
☐ Independent Living Center	☐ Independent Living Center
☐ Mental Health Agency	☐ Mental Health Agency
☐ Benefits Planning	☐ Benefits Planning
☐ School District	☐ School District
☐ Relative	☐ Home Health Agency:_________________
☐ Friend	☐ Provider Agency: ____________________
☐ Internet	☐ Other______________________________
☐ Provider Agency: _______________	
☐ Other__________________________	

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

☐ Mobility or Transfers	☐ Meal Preparation (cooking)
☐ Ambulation	☐ Housework
☐ Getting Dressed	☐ Laundry
☐ Eating	☐ Managing Finances (money)
☐ Toileting / Incontinence	☐ Medication reminders
☐ Personal Hygiene	☐ Shopping
☐ Bathing	☐ Transportation for work
☐ Reminders	☐ 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 Long Term Care Bureau or its designee.

___________________________________ ___________________________
Signature of Applicant Date

___________________________________ ___________________________
Signature of Legal Guardian (if applicable) Date

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