

EMPLOYMENT RELATED PERSONAL ASSISTANCE COMPREHENSIVE CARE PLAN

Participant Name: _____ DOB: _____ Service Coordination Agency: _____

Participant Address: _____ City: _____ State: _____ ZIP: _____

Employer: _____ Medicaid ID: _____ Care Plan Type: Initial Annual Significant Change

EPAS Service Information

HCPCS	Service Name	Provider	Units	Frequency	Begin Date	End Date	Funding Source
	Service Coordination						EPAS
	Financial Management Services						EPAS
S5125	Personal Hygiene						EPAS
S5125	Bathing						EPAS
S5125	Meal Preparation						EPAS
S5125	Ordinary Housework						EPAS
S5125	Laundry						EPAS
S5125	Shopping						EPAS
S5125	Managing Finances						EPAS
S5125	Transportation for work						EPAS

Other Employment Service Information

Service Name	Provider	Units	Frequency	Begin Date	End Date	Funding Source
Vocational Rehabilitation / Job Coaching						
Benefits Planning						

AGREEMENT: I have been presented with the options of service and service providers. I have chosen and agree to accept the services and providers identified in this care plan. I understand that I have the right to appeal if I am denied my choice of service providers or if I am denied services that I believe I am eligible to receive.

Participant/Representative Date

Proxy/Guardian (if applicable) Date Service Coordinator Date

State Medicaid Agency Representative Effective Date

SMA use only:
Enrollment Date _____