

EPIC Program – Use of DHS form 3085 for Employment Retention Reporting

This form needs to be completed the day the customer is enrolled and uploaded to the customer progress page. This form can be used to obtain proof of employment for EPIC customers during the employee retention period (90 days) of the EPIC program.

Access the form from the EPIC Partner Restricted Resources Page by logging into your EPIC dashboard or at this link -

<http://www.dhs.state.il.us/onenetlibrary/12/documents/Forms/IL444-3085.pdf>

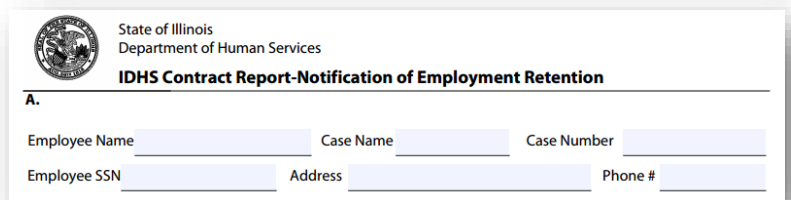
Note: The form is a fillable pdf, but will not save as such if downloaded.

Complete all sections not designated for Employer and mail by US Postal Service to the Employer for verification. If possible, include a self-addressed return envelope.

This form can be included in intake packet information. Complete the customer and contractor information and obtain customer signature. The customer can refuse to sign the form. It should still be uploaded with a note stating the customer did not want to sign.

Complete Section A with the customer information:

- Employee Name is the EPIC Customer Name.
- Case Name is if there is a different name on the IDHS case file. This is possible if there is an aged-out youth still connected to a parent’s case file.
- Case Number is the DHS case ID from the customer profile.
- Employee SSN is the EPIC Customer SSN. Because of this, you cannot email this form to the employer.
- Address is EPIC customer address.
- Phone # is EPIC customer phone number.

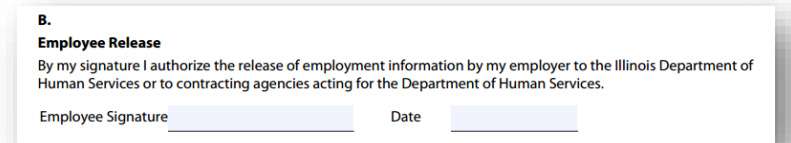


A.

Employee Name _____ Case Name _____ Case Number _____

Employee SSN _____ Address _____ Phone # _____

Complete Section B by having EPIC Customer sign the form. If the EPIC customer signs this at intake, leave the date blank.



B.

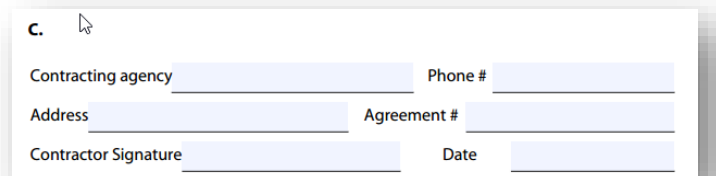
Employee Release

By my signature I authorize the release of employment information by my employer to the Illinois Department of Human Services or to contracting agencies acting for the Department of Human Services.

Employee Signature _____ Date _____

Complete Section C with CBO agency information.

- Contracting Agency is the CBO agency name.
- Phone # is CBO phone number.
- Address is CBO address.
- Agreement # is “EPIC Provider”
- Contractor Signature is Career Navigator signature who is handling the customer case.
- Date is the date the CBO is submitting the form to the Employer.



C.

Contracting agency _____ Phone # _____

Address _____ Agreement # _____

Contractor Signature _____ Date _____

Employer Completes Section D with information that is provided by the employer.

- Employer Name, Phone #, & Employer Address
- Client Job Title, Date of Hire is the EPIC Customer information
- Hourly Wage & Hours per Week
- Medical Benefit Information
- Paid Vacation Information
- Paid Sick Leave Information
- Other Benefits Information
- Future Benefits Information
- Is the individual still employed? If not, provide required information.

D.
Employee Information

Employer Name _____ Phone # _____ Client Job Title _____

Employer Address _____ Date of Hire _____

Hourly Wage _____ Hours per Week _____

Medical Benefits Available? Yes No Co-Pay Amount \$ _____

Paid Vacation Leave Available? Yes No

Paid Sick Leave Available? Yes No

Other Benefits (explain) _____

Explain if benefits will be available in the future _____

Is the individual still employed? Yes No

If no, last date worked _____

Reason for leaving _____

Complete Section E with information provided by the EPIC customer.

Initial Employment Section is for when the EPIC customer is new to a position and includes:

- Employer Name, Phone #, and Address
- Employee Job Title, Start Date, Hourly Wage and Hours per Week
- Medical Benefit Information

Upgraded Employment may be completed for the EPIC customer if the individual receives a promotion. If so, the same information listed above should be filled out on the form. This section is not currently required.

E.
Employment Upgrade
To be completed by the provider and confirmed by the employer (s)

Initial Employment

Employer Name _____ Phone # _____ Employee Job Title _____

Employer Address _____

Start Date _____ End Date _____ Hourly Wage _____ Hours per Week _____

Medical Benefits Available? Yes No Medical Co-Pay \$ _____

Upgraded Employment

Employer Name _____ Phone # _____ Employee Job Title _____

Employer Address _____

Start Date _____ End Date _____ Hourly Wage _____ Hours per Week _____

Medical Benefits Available? Yes No Medical Co-Pay \$ _____

Employer Completes Section F.

- The number of days an EPIC customer has been employed at the company.
- Signature and date
- Employer Name is the printed name of the person completing the form.

F.
Employer Verification

I verify by signing below that all of the employment information listed for the above named employee is correct and that the employee has been employed by this organization for _____ days. (Enter number of calendar days, not work days, from start date to end of job or present date if individual is still employed.)

Employer Signature _____ Date _____

Employer Name _____ Date _____

Upload

Upon receipt of completed form from employer, **upload** document to the customer Progress Page.



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