LOUISIANA DEPARTMENT OF HEALTH
Aging and Adult Services

Legally Responsible Individual (LRI)/Spouse Request Form

This form is used to request for the Legally Responsible Individual (LRI)/spouse of a Community Choices Waiver (CCW) participant to serve as the Personal Assistance Services (PAS) Direct Service Worker (DSW). This form is to be completed by the Direct Service Provider (DSP) or Self-Direction (SD) employer and justifying documentation is required. This form must be submitted to the applicable OAAS Regional Office (RO) via email. RO email addresses are located on the OAAS website at https://ldh.la.gov/index.cfm/directory/category/141.

I. Participant Information			
Participant's Name:		DOB:	
Last 4 digits of SSN:		Region #:	
Address:		Phone #:	
Responsible Representative (if applicable):			
II. Direct Service Provider (DSP) Information			
Name of DSP:			
DSP's Email Address:		Phone #:	
Name of DSP Representative:			
III. Self-Direction Information (if applicable)			
Name of SD Employer:			
SD Employer's Email Address:		Phone #:	
Name of Fiscal Employer Agent (FEA):			

IV. Extraordinary Health Care Needs (Check all that apply and provide explanation.)

☐ Oxygen ☐ Physical/Occupational Therapy ☐ Tube Feeding ☐ Dialysis
☐ Incontinence with Device/Ostomy ☐ Hospice ☐ Suctioning ☐ Other (explain below)
☐ Pressure Ulcers (Stage 4 & non-codeable)

Explanation for the selection(s) above:

V. Extraordinary Care (Check all that apply and provide explanation.)

☐ Inability to locate or hire staff ☐ Staff are not able to provide the needed supports

☐ Spouse has a unique ability to care for the participant (special skill, training, license, etc.)

☐ Other (explain below)

Provide a detailed explanation for the selection(s) above:

VI. Proposed Spouse to be the DSW

Name of Spouse/Proposed DSW:	
DOB:	

Describe any licenses, certifications and/or special training pertaining to the care of the participant:

VII. Acknowledgement

By signing below, I acknowledge that the information and justification provided on this request form is accurate.

DSP Representative/SD Employer Printed Name:

DSP Representative/SD Employer Title:

DSP Representative/SD Employer Signature:

Date Signed:

VIII. OAAS Service Review Panel (SRP) Review and Decision

Additional Information Requested (if applicable):

Date:

☐ Request Approved	Date:	
☐ Request Denied	Date:	