

## 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<br>Agent (FEA):   |           |  |  |
| IV. Extraordinary Health Care Needs (Check all that apply and provide explanation.)   |           |  |  |
| <ul> <li>□ Oxygen □ Physical/Occupational Therapy □ Tube Feeding □ Dialysis</li> <li>□ Incontinence with Device/Ostomy □ Hospice □ Suctioning □ Other (explain below)</li> <li>□ Pressure Ulcers (Stage 4 &amp; non-codeable)</li> <li>Explanation for the selection(s) above:</li> </ul> |           |  |  |

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| V. Extraordinary Care (Chec  | k all that apply and p   | rovide explanation.)                         |  |  |
|--|--------------------------|--|--|--|
| ☐ Inability to locate or hire staff ☐  | Staff are not able to p  | provide the needed supports                  |  |  |
| $\square$ 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) abov    | re:  |  |  |
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|  |                          |  |  |  |
| _  | _                        |  |  |  |
| VI. Proposed Spouse to be t  | he DSW                   |  |  |  |
| Name of Spouse/Proposed DSW:   |                          |  |  |  |
| DOB:   |                          |  |  |  |
| Describe any licenses, certification   | ns and/or special trai   | ning pertaining to the care of the           |  |  |
| participant:   |                          |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
| VII. Acknowledgement   |                          |  |  |  |
|  | t the information and ju | stification provided on this request form is |  |  |
| DSP Representative/SD Employer   | Printed Name:            |  |  |  |
| DSP Representative/SD Employer   | Title:                   |  |  |  |
| DSP Representative/SD Employer   | Signature:               |  |  |  |
| Date Signed:   |                          |  |  |  |
| VIII. OAAS Service Review Pa   | nel (SRP) Review a       | nd Decision                                  |  |  |
| Additional Information Requested   | (if applicable):         |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
|  |                          |  |  |  |
| Date:  |                          |  |  |  |
| ☐ Request Approved   | Date:                    |  |  |  |
| ☐ Request Denied   | Date:                    |  |  |  |

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