Louisiana Department of Health and Hospitals
Office of Aging and Adult Services (OAAS)

Individual Responsibility Agreement (IRA)

Participant	Last 4 Digits of SSN
Legal Representative (if applicable)	

The specific risk/concern described below has been identified and the participant has expressed a preference to take responsibility for addressing this risk/concern. The participant understands that how this risk/concern is addressed may have significant consequences on the participant's health and welfare, including those listed under "Possible Consequences if the Risk/Concern is Not Addressed." The participant acknowledges that the possible consequences of not addressing this risk/concern have been fully explained and, having considered these consequences, chooses to take responsibility for the identified risk/concern. This IRA is supporting documentation for the Plan of Care (POC).

Entering into this agreement does NOT negate any of the participant's rights and responsibilities. Nor does it negate the responsibility for the state or its agents to meet the federal requirements to assure the participants health and welfare. OAAS may terminate this agreement at any time.

a. Identified Risk/Concern
b. Details of the Participant's Plan to Address the Risk/Concern
c. Possible Consequences if the Risk/Concern is Not Addressed

I have read this agreement, understand the content and freely agree to sign it.

_____ _____
Signature – Participant Date

_____ _____
Signature – Legal Representative (if applicable) Date

_____ _____
Signature – SC RN Consultant (if applicable) Date

Signatures of Others Present at IRA Meeting

Name	Title	Agency

This section to be completed by OAAS Regional Office Only

Regional Office Approval : YES ☐ NO ☐

_____ _____
OAAS Regional Office Representative's Signature **Date**

Individual Responsibility Agreement (IRA)

INSTRUCTIONS

Complete the form entirely, including each applicable blank.

- Enter the participant's name and last four digits of social security number.
- Provide details regarding the identified risk/concern for which the participant agrees to take responsibility.
- Describe the participant's plan to address this risk/concern or statements describing a preference to leave the service risk/concern unaddressed.
- Describe the potential consequences to the participant if the identified risk/concern is not addressed.
- Obtain signature(s) from the participant or Legally Authorized Representative and date the form.
- Obtain signature from SC RN consultant and date the form.
- Obtain signature(s), titles & agencies of other individuals present at the IRA Meeting.

Submit completed form to the Regional Office with the Plan of Care for review and approval.