Office of the Long-Term Care Ombudsman Individual Conflict of Interest Screen

All program representatives must complete this form when they begin the certification process, whenever there is a change in their conflict status and annually each federal fiscal year (October to September).

Last Name: _____ First Name: _____

County:_____

Please check all that applies:

- ☐ Initial Screen
- ☐ Annual Screen
- ☐ Annual Screen No Changes
- ☐ Staff
- ☐ Volunteer

Name of Employer: _____

1. Have you or any members of your immediate family or household been employed by or volunteered for a long-term care provider in the last 12 months:

☐ Yes ☐ No

If yes, please list the following:

Dates of Employment/Volunteer: _____

Name of Person Employed/Volunteer: _____

Your Relationship: _____

Employer:_____

Position/Job Duties:_____

Dates of Employment/Volunteer: _____

Name of Person Employed/Volunteer: _____

Your Relationship: _____

Employer:_____

Position/Job Duties:_____

Dates of Employment/Volunteer: _____

Name of Person Employed/Volunteer: _____

Your Relationship: _____

Employer:_____

Position/Job Duties:_____

2. Do you have a member of the immediate family or household that is living in a long-term care facility or is a recipient of long-term care services:

☐ Yes ☐ No

If yes, please list the following:
Your relationship:_____
Facility/Agency: _____

3. Do you or any members of your immediate family or household have any financial interest in any long-term care provider or any agency that funds or regulates the long-term care services?

☐ Yes ☐ No

If yes, please list the following:
Name of Person with Ownership Interest/Investment: _____

Your Relationship: _____

Provider Name and Address: _____

Description of Ownership Interest/Investment: _____

4. Are you or any members of your immediate family or household affiliated with, consultant to, board member of, or have any relationship in which they may profit from a long-term care provider or provider membership organization?

☐ Yes ☐ No

If yes, please list the following:

Name of Person with Affiliation: _____

Your Relationship: _____

Provider/Organization Name and Address:_____

Nature of Affiliation: _____

5. Do you or any members of your immediate family or household stand to gain financially through an action brought on behalf of individuals that the Office of the Long-Term Care Ombudsman serves?

☐ Yes ☐ No

If yes, please describe the applicable action and potential gain that may pose any actual, potential, or perceived conflict of interest:

_____
_____
_____
_____
_____
_____

6. Do you have responsibility in any of the following program areas within the agency in which you are employed?

☐ Adult Protective Services

☐ Older Adult Protective Services

☐ Pre-Admission Screening

☐ Discharge Planning

☐ Case Management

☐ Guardianship

7. Are you a mandated abuse reporter?

☐ Yes ☐ No

If yes, please explain the license you hold, paid employment or volunteer position that requires you to be a mandated abuse reporter?

_____
_____
_____
_____
_____

If any questions are answered yes or any items in Question #6 are checked, please explain below how the conflict will be remedied. The proposed remedy will be reviewed by a representative of the State Office. The remedy will be approved or denied. A "Conflict Identified" form must also be completed. These two completed and signed forms are submitted to your program specialist.

A program representative who has a conflict should not continue with the onboarding process until the proposed remedy to their conflict has been approved.

Proposed Remedy to a Conflict:

_____
_____
_____
_____

Signatures Required for All Forms (Conflict and No Conflict)

Signed: _____ Date: _____
(Program Representative)

Signed: _____ Date: _____
(Program Representative Supervisor or Mentor)

State Office Approval: _____State Office Denial:_____ Date:_____

State Office Comment(s):

_____
_____
_____
_____