



Office of the State Long-term Care Ombudsman
Conflict of Interest Identification, Removal and Remedy

Name of person completing this form

Type of conflict <input checked="" type="checkbox"/> Individual <input type="checkbox"/> Organizational	Date conflict was identified
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If individual:

Name of person with conflict

Title

Ombudsman Program

1. Describe the conflict:

2. What is the scope of the conflict? <i>Specify organizations and businesses affiliated with the conflict including businesses operated by the same owner.</i>

3. Identify areas that require changes to Ombudsman Program procedure. Include any changes to:

- *Ombudsman intake procedures*
- *Contact with residents*
- *Communications with providers, facility staff, owner, or host agency staff*
- *Complaint-handling procedure*
- *Employment or volunteer responsibilities within the local ombudsman entity*
- *Other changes, explain:*

4. Describe how the conflict will be remedied or removed. Address each issue noted in Item 3 above and the following as applicable:

- If a current or previous financial relationship with a long-term care facility, say how this relationship will not negatively affect the Ombudsman Program.
- If a current or previous personal relationship with one or more residents in a long-term care facility, say how this relationship will not negatively affect the ombudsman's role as an advocate for all residents in the assigned facility or facilities.
- If the conflict involves membership or volunteer activities relating to long-term services and supports, say how the activity will not negatively affect the Ombudsman Program.
- If an organizational conflict, address all functions affected by the conflict.

5. Who will the individual or local ombudsman entity report to within the host agency?

Name and title
Describe how the arrangement will be monitored for effectiveness

6. What is the expected duration of this conflict and plan?

7. Signatures

Signature — Ombudsman/Applicant

Date

Signature — Managing Local Ombudsman

Date

Signature — Host Agency Representative

Date

For State Office Use Only:

Decision by State Ombudsman

Approved <input type="checkbox"/> Yes <input type="checkbox"/> No	Note: _____
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Modifications: *For example time limits and other direction noted by the State Ombudsman above*

Signature

Date