The National Long-Term Care Ombudsman Resource Center

SCREENING TEMPLATE

LONG-TERM CARE OMBUDSMAN PROGRAM INDIVIDUAL CONFLICT OF INTEREST SCREENING TEMPLATE

This document contains information based on the LTCOP Rule, §1324.21(d), Conflicts of Interest. The content is adapted from similar tools developed by State Ombudsman programs, such as Ohio, Texas, Oklahoma, and Iowa. This template is intended for use as a guide when Ombudsman programs develop or revise individual conflict of interest screening tools. States are responsible for adding any state specific requirements, definitions, or processes that may not be included in this document. Additional information on individual conflicts of interest, the provisions in the Rule, and examples of screening tools used by Ombudsman programs can be accessed here.

Name: **Date:**

Address: **Phone:**

Email Address:

Employment and Responsibilities

Have you or any members of your immediate family or household ever been employed by a long-term care provider (facility or by the owner or operator of a facility)? Immediate family means a member of the household or a relative with whom there is a close personal or significant financial relationship. (§712 of the Older Americans Act, §1324.1, Definitions, LTCOP Rule.) **Yes** ☐ **No** ☐

Do you, or any members of your immediate family or household, receive or have the right to receive, directly or indirectly remuneration (in cash or in kind) under a compensation arrangement with an owner or operator of a long-term care facility? **Yes** ☐ **No** ☐

Are you working for, or have you worked for, an association (or an affiliate of an association) of long-term care facilities or of any other residential facilities for older individuals or individuals with disabilities? **Yes** ☐ **No** ☐

Are you providing care, or have you provided care, for residents of long-term care facilities or involved in the provision of personnel for long- term care facilities? **Yes** ☐ **No** ☐

Are you currently participating in the licensing, certification, and/or surveying of long-term care facilities, or have you in the past? **Yes** ☐ **No** ☐

If you answered Yes to any of the above questions, please list the following.

Start/End dates of employment (MM/YY)	Name of person employed or compensated	Your relationship	Employer	Position/duties or Compensation Arrangement

Are you currently performing any of the responsibilities listed below? *Check all that apply.*

- ☐ Providing long-term care coordination or case management for residents of long-term care facilities.
- ☐ Providing adult protective services.
- ☐ Participating in eligibility determinations regarding Medicaid or other public benefits for residents of long-term care facilities.
- ☐ Conducting pre-admission screening for long-term care facility placements.
- ☐ Making decisions regarding admission or discharge of individuals to or from long-term care facilities.
- ☐ Providing guardianship, conservatorship, or other fiduciary or surrogate decision-making services for residents of long-term care facilities.

For all responsibilities that were checked, describe your role, and provide additional information.

Are you serving as an officer or board member of a long-term care facility or service provider? **Yes** ☐ **No** ☐

If **Yes**, please provide additional information, such as your position, length of service, responsibilities, etc.

Financial Interest

Do you or any member of your immediate family or household have an ownership or investment interest (represented by equity, debt, or other financial relationship) in an existing or proposed long-term care facility or service?
Yes ☐ **No** ☐

If **Yes**, please provide information regarding the financial interest including as applicable, the location of the facility and/or the area covered by the service.

Relationships

Do you, or a member of your immediate family or household, have an immediate family member residing in a long-term care facility? **Yes** ☐ **No** ☐

Do you or have you resided in a long-term care facility? **Yes** ☐ **No** ☐

If **Yes**, to either of the questions, please list the following.

Name of Facility	Location of Facility	Your relationship or length of time

Are you serving individuals who live in long-term care facilities in any capacity, such as a volunteer visitor, conducting pet therapy, providing entertainment, or any other services, paid or volunteer? **Yes** ☐ **No** ☐

If **Yes**, provide additional information.

Name of Facility	Location of Facility	Your Role	Frequency

Additional Considerations

Do you, or a member of your immediate family or household, have any other relationships, activities, or responsibilities that may impact the effectiveness and credibility of the work of the Office of State Long-Term Care Ombudsman (Office)? **Yes** ☐ **No** ☐

If **Yes**, please list them. If you are not sure about the potential impact on the Office, please list the relationship, activity, or responsibility, for discussion with a staff Ombudsman program representative.

Agreements

As a representative of the Office, I understand that I, and members of my immediate family and household, cannot:

- accept gifts or gratuities of significant value from a long-term care facility or its management, a resident or a resident representative of a long-term care facility in which I serve;
- accept money or any other consideration from anyone other than the Office, or an entity approved by the Ombudsman, for the performance of an act in the regular course of my duties as a representative of the Ombudsman program without Ombudsman approval.

If any circumstances in this document change or if I have questions or concerns regarding an actual or potential conflict of interest with my duties as a representative of the Office, I will notify my direct Ombudsman program supervisor immediately.

If any circumstances or opportunities arise and I have questions or concerns regarding the potential impact on the effectiveness or credibility of the Ombudsman program, I will notify my direct Ombudsman program supervisor immediately.

I understand and agree with the preceding statements and verify that all of the information I have provided is accurate.

_____ _____

Signature Date

For Program use only

After reviewing this document and speaking with the applicant, it has been determined that the following conflict of interests can and will be remedied and supporting documentation is included with this application.

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_____

It has been determined (through conversation with the applicant) that the following conflicts of interests **cannot** be remedied, and the applicant has been notified (or will be notified). ☐Yes ☐ No

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_____

Per our state policies and procedures, the pertinent information for designation by the State Ombudsman was forwarded to the State Office.

Staff name and signature: _____ Date: _____

This project was supported, in part by grant number 90OM002, from the US Administration for Community Living, Department of Health and Human Services, Washington, DC 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.