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

Name_____Date_____Region_____

Please check all that apply: **Initial screen**_____ **Annual screen**_____

Potential or current: **volunteer**_____ **employee**_____ **board member**_____
person(s) involved in designating regional program director _____

1. Have you or any members of your immediate family or household ever been employed by a long-term care provider? **Y** **N**

   If yes, please list for each long-term care and/or in-home service provider the following information: name of person employed, your relationship, employer's name, dates of employment, and the position/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? **Y** **N**

   If yes, please describe the relationship and identify the 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 long-term care services? **Y** **N**

   If yes, please list for each applicable long-term care provider the following information: name of person with ownership interest/investment, your relationship, the provider's name and address, and the extent of the ownership interest or 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? **Y** **N**

If yes, please list the following for each affiliation: name of person with the affiliation, your relationship, the provider and/or organization's name and address, and the nature of the affiliation.

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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 Long-Term Care Ombudsman Program serves?

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

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_____

Signed_____Date_____
(Applicant/Representative)

Signed_____Date_____
(Regional Program Reviewer)

Request for Waiver and Proposed Remedy to Identified Conflict of Interest

State Ombudsman Approval:_____Date_____

State Ombudsman Denial:_____Date_____

Comment:_____

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