Ohio SLTCOP
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.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

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.

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

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:________________________________________________________________

__________________________________________________________________________