TEXAS
Department of Aging
and Disability Services

Form 8607
March 2017-E

Office of the State Long-term Care Ombudsman

Conflict of Interest Screening of a Representative of the Office

Name of person completing this form

An individual conflict of interest means a situation in which a person is involved in multiple interests, financial or otherwise, that could impact the effectiveness and credibility of the work of the Ombudsman Program.

An ombudsman intern or certified ombudsman must immediately inform the Managing Local Ombudsman (MLO) when a conflict of interest exists or might exist. All certified ombudsmen must be screened before performing functions of the Ombudsman Program and annually thereafter.

1. In the last 12 months, have you or an immediate family member:

   a. Been involved in the licensing or certification of a nursing home or assisted living facility (LTC facility), day activity and health services (DAHS), or home and community support services agency (HCSSA)? ☐ Yes ☐ No

If Yes, what facility or agency?

Your role

   b. Provided contract services to an LTC facility or worked for an agency or business that provides services to an LTC facility or a resident of an LTC facility? (Examples: therapy, counseling, pharmacy services, nurse staffing and lawn services) ☐ Yes ☐ No

Your role

   c. Had the right to receive, directly or indirectly, payment (in cash or in-kind) under a compensation arrangement with an owner or operator of an LTC facility, DAHS, or HCSSA? ☐ Yes ☐ No

If Yes, what facility or agency?

Your role

   d. Been involved in making Medicaid, Medicaid managed care, Medicare, or PASRR decisions for someone other than your immediate family member? ☐ Yes ☐ No

If Yes, describe your role.

   e. Received gifts, gratuities or other considerations from an LTC facility, a resident of an LTC facility, or a resident's family? ☐ Yes ☐ No

If Yes, what facility?

2. Have you owned or had investment interest (equity, debt, or other financial relationship) in an LTC facility, DAHS, HCSSA, personal care service, or a business that makes referrals to an LTC facility? ☐ Yes ☐ No

If Yes, what facility or agency?

Your role

3. Have you managed or worked for an LTC facility, DAHS, HCSSA, personal care service, or business that makes referrals to an LTC facility, or a managed care organization in Texas? ☐ Yes ☐ No

If Yes, what facility or agency?	Last date of employment
Your role	

4. Do you have a relative who lives or works in an LTC facility in Texas? ☐ Yes ☐ No

If Yes, identify your relation to the relative and what facility they live or work in

5. Do you currently serve as a guardian, a power of attorney, or a primary decision-maker for a resident in an LTC facility in Texas? ☐ Yes ☐ No

If Yes, please describe

6. Are you a volunteer for an LTC facility, including serving on a board or council, providing religious services or consulting? ☐ Yes ☐ No

If Yes, identify the facility and describe your role

Answering "Yes" to any of the questions above indicates a potential conflict of interest. If a conflict is identified, the MLO may submit a plan to identify and remove the conflict to the Office of the State Long-term Care Ombudsman (Office) using the "Conflict of Interest Identification, Removal, and Remedy" form. The form must be approved by the Office before the person performs functions of the Ombudsman Program, or for a certified ombudsman, within 30 calendar days of identifying the conflict. The Office approves, modifies, or denies the plan.

Failure to identify and remove a conflict of interest will result in refusal or termination of certification of the individual.

☐ I certify that I have read and understand this Conflict of Interest form and I have no conflicts.

☐ I certify that I have read and understand this Conflict of Interest form and I notified the MLO of the following potential conflict:

Describe Each Conflict

Signature — Ombudsman Intern or Certified Ombudsman	Date	Signature — Managing Local Ombudsman	Date

Retain original at local office of the Ombudsman Program. If submitting a removal or remedy plan for approval by the Office of the State Long-Term Care Ombudsman, provide a copy of this completed form with the removal or remedy plan.

TEXAS
Department of Aging
and Disability Services

Form 8613
March 2017-E

Office of the State Long-term Care Ombudsman

Conflict of Interest Identification, Removal and Remedy

Name of person completing this form

Type of conflict	Date conflict was identified
☑ Individual ☐ Organizational	

If individual:

Name of person with conflict
Title
Ombudsman Program

1. Describe the conflict:

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

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	Note:
☐ Yes ☐ No	

Modifications: *For example time limits and other direction noted by the State Ombudsman above*

Signature

Date