



STATE OF WISCONSIN  
 BOARD ON AGING AND LONG TERM CARE  
 1402 Pankratz Street, Suite 111  
 Madison, WI 53704-4001

Ombudsman Program (800) 815-0015  
 Medigap Helpline (800) 242-1060  
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 Fax (608) 246-7001  
<http://longtermcare.wi.gov>

MEMBERS of the BOARD  
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 Dr. Dale B. Taylor  
 EXECUTIVE DIRECTOR  
 And  
 STATE LONG TERM  
 CARE OMBUDSMAN  
 Heather A. Bruemmer

**Conflict of Interest Disclosure Form**  
**Volunteer Ombudsman Program Applicant-Potential Volunteer**

Name of Potential Volunteer: \_\_\_\_\_  
 Name of Volunteer Coordinator: \_\_\_\_\_

Federal law<sup>1</sup> requires the Board on Aging and Long Term Care (BOALTC) to report any current or potential conflicts of interest which may impact the Volunteer Ombudsman Program (VOP). Individual conflicts of interest must be identified when a conflict exists or might exist. Conflicts of interest will be considered in determining eligibility to become a Volunteer Ombudsman. Disclosure of any potential conflicts of interest must also be reported immediately to BOALTC as they arise. Completion of a conflict of interest form is required annually.

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

Reasonable steps must be taken to identify and remove or remedy conflicts of interest. When a conflict has been identified, it is the responsibility of the potential Volunteer Ombudsman to remove or remedy such conflict, with the assistance of BOALTC. Some conflicts of interest might not be able to be remedied. The State Ombudsman has full authority to determine if a conflict can be remedied and to approve any remediation plans. If a conflict cannot be remedied, the applicant is ineligible to become a Volunteer Ombudsman.

**If answering YES to a question below, identify dates, facility/company name, location, identity of individual and your relationship to the individual and ANY other pertinent facts, as applicable. Attach additional pages as needed.**

1. Have you or an immediate family member ever had direct involvement in the licensing, regulation, surveying, or certification of a long-term care facility?  YES  NO

\_\_\_\_\_  
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 \_\_\_\_\_  
 \_\_\_\_\_

<sup>1</sup> 42 U.S.C. § 3058g, 45 CFR § 1324.21

2. Have you or an immediate family member ever had ownership, operational, financial or investment interest in an existing or proposed long-term care facility?  YES  NO

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3. Have you or an immediate family member ever been employed by a long-term care facility, managed care organization (MCO), self-directed services program (IRIS) or a business that provides contracted services to a long-term care facility?  YES  NO

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4. Do you or an immediate family member have any right to receive compensation of any kind from a long-term care facility?  YES  NO

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5. Is a member of your immediate family currently residing in a long-term care facility or have they resided within a long-term care facility in the past two years?  YES  NO

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6. Are you serving as a guardian, conservator, power of attorney agent or Supporter under a Supported Decision-Making agreement for a resident of a long-term care facility?  YES  NO

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7. Are you currently serving long-term care residents in any capacity, paid or volunteer?  
Ex: volunteer visitor, pet therapy, providing entertainment.  YES  NO

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8. Are you a member of any organization addressing long-term care issues, including but not limited to acting as a consultant, serving on a board, advisory council or committee?  YES  NO

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9. Do you hold a current professional license which has mandatory reporting requirements?  
(ex: social work license)  YES  NO

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10. Have you ever filed a complaint against a long-term care facility with the Division of Quality Assurance (DQA)?  YES  NO

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11. Have you ever filed a lawsuit against a long-term care facility?  YES  NO

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12. Have you had any prior personal or professional experience with the Ombudsman or Volunteer Ombudsman Program?  YES  NO

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13. 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 Ombudsman and Volunteer Ombudsman Program?  YES  NO

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Check one of the following:

- I certify that I have read and understand this form and I have no conflicts.
- I certify that I have read and understand this form and I have disclosed above any potential conflicts that may exist.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**For State Office Use Only:**

**Decision by State Ombudsman:**

- Approved
- Remediation Needed
- COI cannot be remedied

Comments:

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Heather A. Bruemmer  
State Long Term Care Ombudsman  
Executive Director