State Long-Term Care Ombudsman

# Office of the State Long-Term Care Ombudsman
# Conflict of Interest Screening Form

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**Instructions:** Please fill out this form as accurately and thoroughly as possible and return to the Regional Program Director, Volunteer Coordinator, or Supervisor.

**Purpose:** Screenings are used to determine perceived or actual conflicts of interest (COI) between ombudsmen employees and volunteers, new candidates, board members, sponsoring agency staff and long-term care facilities/service providers. COI screenings should be completed upon initial hire, annually, and as new conflicts arise. Not all COIs are a concern of the Office and may easily be addressed by assigning ombudsmen to communities or facilities where they do not have a conflict. **COIs include any scenario below marked as 'Yes'.**

| Last Name | First Name |
|---|---|
| | |

**OFFICE USE - Check all that apply:**

| Initial Screen | Newly Identified Conflict of Interest | Annual Screen |
|---|---|---|
| ☐ | ☐ | ☐ |

| New Candidate | Volunteer | Employee | Board Member | Sponsoring Agency Staff |
|---|---|---|---|---|
| ☐ | ☐ | ☐ | ☐ | ☐ |

**1.** Are you **currently** or have you **ever** been employed at a long-term care facility or by a long-term care service provider? For example, Nursing Homes, Meals on Wheels, Home Health, Adult Day Care, Area Agency on Aging:

**Yes** ☐ **No** ☐

If **yes,** how recent was the employment? If **no**, skip to the next question.

**Within the last two years** ☐ **More than two years ago** ☐

**2.** Do you have any **immediate family members currently** employed at a long-term care facility, service provider, or licensing/certification of a long-term care facility? Immediate family means a member of the household or a relative with whom there is a close personal or significant financial relationship.

**Yes** ☐ **No** ☐



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If **yes** to any of the above questions, please list the following:

| Start/End Dates of Employment (Month/Yr – Month/Yr) | Name of Person Employed | Relationship | Long-Term Care Facility/Service Provider | Position/Duties |
|---|---|---|---|---|
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**3.** Do **you** participate or work at an agency that performs the licensing, certification, and/or surveying of long-term care facilities, or have you in the past?

**Yes** ☐ **No** ☐

If **yes,** please check all the responsibilities that apply below:

- ☐ 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 admissions.
- ☐ Conducting inspections or surveys of long-term care facilities.
- ☐ Making decisions regarding admission or discharge of individuals to or from long-term care facilities.
- ☐ Other

| Start/End Dates of Employment (Month/Yr-Month/Yr) | Long-Term Care Agency/Organization | Position/Duties |
|---|---|---|
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**4.** Do you **currently** have any **immediate family members** who live in a long-term care facility or receive long-term care services:

**Yes** ☐ **No** ☐

If **yes,** please list the following:

| Relationship | Long-Term Care Provider |
|---|---|
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**5.** Are you **currently** serving as a guardian, conservator, or in another fiduciary or surrogate decision-making capacity for a person receiving long-term?

**Yes** ☐ **No** ☐

If **yes,** please list the following:

| Name of Person Serving as Guardian/Conservator/Surrogate | Relationship | Agency/Organization (if applicable) | Long-Term Care Provider or Service of Ward(s) |
|---|---|---|---|
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**6.** Are **you** or any **immediate family member** receiving compensation through ownership, investment interest (represented by equity, debt, or other financial relationship), or 'in cash/in kind' (directly or indirectly) arrangements with a long-term care facility or service provider?

**Yes** ☐ **No** ☐

If **yes,** please list the following:

| Name of Person with Financial Interest | Relationship | Long-Term Care Facility/Service Provider | Description of Financial Interest/Affiliation |
|---|---|---|---|
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**7.** Do **you** have any other relationships, activities, duties or responsibilities that may create a real or perceived conflict or otherwise impact the credibility of the work of the Office of State Long-Term Care Ombudsman? For example, relative that used to live in a facility, acting as a volunteer visitor, conducting pet therapy, providing entertainment, religious activities, litigation or any other services, as an employee or volunteer, in long-term care facilities.

**Yes ☐ No ☐**

If **yes**, please list them. If you are unsure of the potential impact, please list the relationship, activity, duties or responsibility for discussion with an Ombudsman program representative.

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_____

**Signed**_____ **Date**_____

**(Applicant/Representative)**

**Signed**_____ **Date**_____

**(Program Reviewer/Supervisor)**

*Office Use Only – Follow State Long-Term Care Ombudsman Program instructions for submission.*