Office of the State Long-Term Care Ombudsman

Conflict of Interest Screen

Please Print Clearly

Ombudsman
Expect Excellence in Your Care

Last name	First name	Region

Please check all that applies:

Initial screen	Annual screen	Annual screen with no change (approval attached)	Volunteer	Employee	Board member	Person(s) involved in hiring program director

1. Have you or any members of your immediate family or household ever been employed by a long-term care provider: Yes_____ No_____

If yes, please list the following:

Start/End dates of employment (MM/YY)	Name of person employed	Your relationship	Employer	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: Yes_____ No_____

If yes, please list the following:

Your relationship	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 the long-term care services? Yes_____ No_____

If yes, please list the following:

Name of person with ownership interest/investment	Your relationship	Provider Name & Address	Description of 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? Yes_____ No_____

If yes, please list the following:

Name of person with the affiliation	Your relationship	Provider/Organization name & address	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? Yes_____ No_____

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)

Please check all that apply:

New conflict & remedy	Old conflict & remedy (approved previously)	Previously approved conflict & remedy attached	Request for waiver

Request for waiver and/or proposed remedy to the identified conflict of interest:

SLTCO Comment(s):

State Ombudsman Approval:_____ **Date:**_____

State Ombudsman Denial:_____ **Date:**_____