

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, Day Activity and Health Services (DAHS) or Home and Community Support Services (HCSSA)? .....  Yes  No

If yes, what facility or agency?

Your role:

- b. Provided contract services to a Long-Term Care (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 Preadmission Screening and Resident Review 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 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. a. 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:

b. Does this relative meet the definition of immediate family member, defined as a member of the same household or relative with whom there is a close personal or significant financial relationship? .....  Yes  No

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

If yes, describe the relationship and identify the facility.

6. Do you volunteer in an LTC facility, including religious services, consulting services, or serving on an LTC facility board or council? .....  Yes  No

If yes, describe.

7. List any LTC facility where you have a prior or current personal relationship with staff, contractors, consultants, therapists, home health or hospice employees, or volunteers.

Describe each relationship, including the name and role of the person at the facility.

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 a potential conflict.

Signature — Ombudsman Intern or Certified Ombudsman: \_\_\_\_\_ Date: \_\_\_\_\_

**This section must be completed by the MLO.**

All placement restrictions must be approved by the Office of the State Long-Term Care Ombudsman (Office).

The MLO considers the representative of the Office identified on this form to not have a conflict of interest, but has determined the representative may not be assigned to the following facilities:

[names of all facilities where this individual cannot provide ombudsman services]

Answering "Yes" to any of the questions above indicates a potential conflict of interest. To avoid the appearance of a conflict, the MLO may suggest a facility placement restriction. Or, to remedy an identified conflict, the MLO may submit a plan to identify and remove the conflict to the Office. Both a facility placement restriction or the plan to identify and remove the conflict must be approved by the Office before the person performs functions of the Ombudsman Program, within 30 calendar days for a certified ombudsman that is not the MLO, and within five days for an MLO. The Office approves, modifies or denies the plan. In accordance with 26TAC §88.303 and §88.403(c), failure to identify and remove a conflict of interest will result in refusal or termination of certification of the individual.

Signature — Managing Local Ombudsman: \_\_\_\_\_ Date: \_\_\_\_\_

**This section is completed by the Office for a representative of the Office who is an HHS employee and for any representative of the Office for whom a placement restriction is recommended.**

Placement Restriction Approved

Placement Restriction Not Approved (Must Submit HHSC Form 8613 to the State Ombudsman for approval.)

Signature — State Long-Term Care Ombudsman or Designee: \_\_\_\_\_ Date: \_\_\_\_\_

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