Office of the Long-Term Care Ombudsman

Individual Conflict of Interest Screen

FY 2018-19

LAST NAME	FIRST NAME	COUNTY
		Lehigh /Northampton

Please check all that applies:

INITIAL SCREEN	ANNUAL SCREEN	ANNUAL SCREEN NO CHANGES	STAFF	VOLUNTEER	NAME OF EMPLOYER
					Catholic Charities Diocese of Allentown

1. Have you or any members of your immediate family or household been employed by a long-term care provider in the last 12 months:

Yes________ No___ _____

If yes, please list the following:

DATES OF EMPLOYMENT	NAME OF PERSON EMPLOYED	YOUR RELATIONSHIP	EMPLOYER	POSITION/JOB 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____X____

If yes, please list the following:

NAME OF PERSON WITH OWNERSHIP OR INTEREST/INVESTMENT	YOUR RELATIONSHIP	PROVIDER NAME AND 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 AND 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 Office of the Long-Term Care Ombudsman serves? Yes________ No________

If yes, please describe the applicable action and potential gain that may pose any actual, potential, or perceived conflict of interest.

6. Do you have responsibility in any of the following program areas within the agency in which you are employed?

Check all that apply:

- ❑ **Adult Protective Services**
- ❑ **Older Adult Protective Services**
- ❑ **Pre-admission Screening**
- ❑ **Discharge Planning**
- ❑ **Case Management**
- ❑ **Guardianship**

If items are checked, please describe the steps that will be taken to remove the conflict.

Signed____
Date_______________________________
(PROGRAM REPRESENTATIVE)

Office of the Long-Term Care Ombudsman

Individual Conflict of Interest Screen

FY 2018-19

Signed____
Date_________________________________
(PROGRAM REPRESENTATIVE SUPERVISOR

SLTCO Comment(s):

State Ombudsman Signature Approval: ___________________________ Date: _______

State Ombudsman Signature Denial: _____________________________ Date: _______