Conflict Identified

FY 2016-17 Program Representative Conflict of Interest Identification Form

Instructions: Each program representative is required to fill out this form individual and submit to his/her assigned regional ombudsman specialist. An ombudsman program representative is defined in APD 16-10-01, Office of the State Long-Term Care Ombudsman Program, as employees or volunteers who are designated by the State Long-Term Care Ombudsman to perform the duties set forth in §1324.19(a).

Once this form has been completed, it will need to be re-named to identify the name of the individual program representative. ***For example Ollie Ombudsman lives in Sunny Hill County. Ollie's form would be titled "Ollie Ombudsman – Sunny Hill County – Conflict of Interest Identification Form".***

I, ________________________________, PA Long-Term Care Ombudsman Program Representative, declare that I have a conflict of interest in one or more areas related to the performance of my ombudsman duties as listed on the attached document. This has been disclosed to and verified by my ombudsman program supervisor. I understand that the next step is to remedy this/these conflicts and provide a detailed description on how and when this will occur. I understand that if any other conflicts should arise in the future that I will need to fill out another disclosure form and submit to my assigned regional ombudsman specialist when I become aware of the conflict.

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Signature of Program Representative Date