Texas Department of Aging and Disability Services

State Long-Term Care Ombudsman Program

Ombudsman Volunteer Application

Form 8621
June 2005

This form is provided as a service by the Texas Department of Aging and Disability Services. The local Ombudsman Program may require additional information. A criminal history check will be required before acceptance into the ombudsman training program. Send this form to the local Ombudsman Program serving your address.

Name	Other Names Used (Maiden Name, Nicknames)	Date

Address	City, ZIP Code	Home Area Code and Telephone No.
		( ) —

E-mail Address	Work/Other Area Code and Telephone No.
	( ) —

Employment Status	Emergency Contact Name	Area Code and Telephone No.
☐ Full-Time ☐ Part-Time ☐ Retired ☐ Student ☐ Other		( ) —

Do you speak any languages other than English?	If yes, which language(s):
☐ Yes ☐ No	

Describe your experiences:

☐ working with the elderly:

☐ with nursing or assisted living facilities, e.g., ever worked in a facility, placed a relative in a facility:

☐ as a volunteer:

What hobbies, interests, and organizations are you involved in?

Are you currently employed by or help in the operation of a long-term care facility? ☐ Yes ☐ No If yes, explain:

Do you have a family member employed by or connected with a business interest in a long-term care facility? ☐ Yes ☐ No

If yes, explain:

Have you ever been convicted or pled guilty to a misdemeanor or felony? ☐ Yes ☐ No If yes, explain (a criminal history check will be conducted before accepting anyone into the Ombudsman Program):

Availability: Will you be available at least two hours each week at various times during the week? ☐ Yes ☐ No Other? If yes, explain:

How did you learn about the Ombudsman Program?
Why do you want to be an ombudsman?
Additional Comments:

References. Please provide the name, address, and telephone number of at least two references whom we may contact:

Name	Relationship	Home Area Code and Telephone No. ( ) —
Address	City, State, ZIP Code	Work Area Code and Telephone No. ( ) —
Name	Relationship	Home Area Code and Telephone No. ( ) —
Address	City, State, ZIP Code	Work Area Code and Telephone No. ( ) —

Signature—Applicant

Date

TEXAS
Department of Aging
and Disability Services

Form 8607
March 2017-E

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 (LTC facility), day activity and health services (DAHS), or home and community support services agency (HCSSA)? ☐ Yes ☐ No

   If Yes, what facility or agency?

   Your role

   b. Provided contract services to an 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 PASRR 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 managed or 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. 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

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

If Yes, please describe

6. Are you a volunteer for an LTC facility, including serving on a board or council, providing religious services or consulting? ☐ Yes ☐ No

If Yes, identify the facility and describe your role

Answering "Yes" to any of the questions above indicates a potential conflict of interest. If a conflict is identified, the MLO may submit a plan to identify and remove the conflict to the Office of the State Long-term Care Ombudsman (Office) using the "Conflict of Interest Identification, Removal, and Remedy" form. The form must be approved by the Office before the person performs functions of the Ombudsman Program, or for a certified ombudsman, within 30 calendar days of identifying the conflict. The Office approves, modifies, or denies the plan.

Failure to identify and remove a conflict of interest will result in refusal or termination of certification of the individual.

☐ 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 the following potential conflict:

Describe Each Conflict

Signature — Ombudsman Intern or Certified Ombudsman	Date	Signature — Managing Local Ombudsman	Date

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

State Long-term Care Ombudsman Program

Code of Ethics

As a certified ombudsman, I am subject to a code of ethics similar to others in the long-term care field. I assume responsibilities and accountability for my actions as a representative of the Department of Aging and Disability Services Office of the State Long-term Care Ombudsman. I recognize and adhere to the following points of ethics, and as a certified ombudsman will endeavor to:

1. Participate in efforts to maintain and promote the integrity and credibility of the long-term care ombudsman program.

2. Provide services with respect for human dignity and the individuality of the resident unrestricted by considerations of age, ethnicity, medical condition, source of payment, social or economic status, personal characteristics or lifestyle choices.

3. Provide professional advocacy services unrestricted by personal belief or opinion.

4. Recognize the boundaries of my own level of training and skills and consult with my supervising staff ombudsman or the Office when needed.

5. Maintain competence in areas relevant to long-term services and supports, including regulatory and legislative information and long-term care service options.

6. Assure the resident's rights as reflected in federal and state laws and regulations are known by and applied to the residents for whose protection they were written.

7. Respect and promote the resident's right to self-determination, making every reasonable effort to ascertain and act in accordance with the resident's wishes.

8. Safeguard the resident's right to privacy by protecting confidential information and acting only with proper consent from the resident.

9. Participate in efforts to promote a quality long-term care system and act to protect vulnerable individuals from abuse and neglect.

10. Adhere to policies and procedures of the Texas Long-term Care Ombudsman Program and sponsoring agency.

I will do my utmost to uphold this code, as I understand the effectiveness and credibility of the ombudsman program depends, in part, on the way I carry out my responsibilities. The Office requires this signed Code of Ethics for my current certification as a long-term care ombudsman.

_____ _____

Signature Date

Retain original at local LTCOP

Long-term Care Ombudsman Program

Consent for Criminal History Check

All representatives of the Office of the State Long-term Care Ombudsman, both volunteers and staff, entering the Ombudsman Program must complete a criminal history check and have no barring criminal convictions.

Each applicant gives permission to the Department of Aging and Disability Services Long-term Care Ombudsman Program (LTCOP) to perform an initial criminal history check and periodic checks thereafter. Volunteers and staff must immediately report criminal charges, indictments or convictions to the LTCOP. All names ever used by the applicant must be disclosed.

I, _____, authorize the Long-Term Care Ombudsman Program to request a criminal history check on me to serve as a:

☐ Certified Volunteer Ombudsman ☐ Certified Staff Ombudsman ☐ Friendly Visitor ☐ Other _____

List every name ever used:

_____

_____

_____

List any pending legal charges: _____

Current or previous related license or certification: _____.

My birth date is: _____.

My Texas Department of Public Safety (TDPS) driver license or TDPS identification card number is: _____.

An out-of-state license requires my Social Security number: _____.

I certify the information listed above is correct.

_____
Printed Name

_____ _____
Signature Date

To be completed by the local Long-term Care Ombudsman Program:

I have examined the government issued ID of this applicant and verify the above information is correct.

_____
Managing Local Ombudsman/Designee

_____ _____
Ombudsman Program/Area Agency on Aging Date

Fax to: 512-438-3233
Retain original at local LTCOP