

POTENTIAL CONFLICT OF INTEREST
DISCLOSURE NOTICE

This document is designed to verify employees, close relatives of employees or members of an employee's immediate household are **income eligible for HACAP services and that eligible employees do not receive any priority**. If as an Employee or Program Manager you are unsure if the client meets the criteria for a "Potential Conflict of Interest" please continue with the process-fill out the form, verify information and route for appropriate signatures.

1. Please accept this as notification that (Applicant's Name) _____, is requesting the following HACAP services: _____

a. Applicant is a HACAP employee: (check one) **YES-if yes, proceed to Questions 5-9** **No**

b. Applicant is a close relative or member of immediate household: (check one) **Yes** **No**

If yes, is HACAP employee aware relative is requesting services: (check one)
Yes-If yes, proceed to Questions 2-9. No-If no, proceed with Questions 5-9.

Questions 2-4 completed by HACAP employee (only if the employee is aware service is being delivered or is part of the service application or selection process).

2. My relationship to the applicant is: _____

3. I work in what department/program of HACAP: _____

4. This person is a member of my immediate household: (check one) **Yes** **No**

By signing this form, I verify I was not involved in the completion of the application or the selection process for the requested HACAP services.

HACAP Employee (Print)

Signature of HACAP Employee

Date

Questions 5-8 completed by Program Manager (maintaining client confidentiality is critical-if an employee is unaware of the service being delivered or is not part of the application or selection process they do not fill out questions 1-4).

5. I have personally verified the application and eligibility documentation: (check one) **Yes** **No**

a. Applicant meets the program's income eligibility documentation: (check one) **Yes** **No**

b. Applicant is requesting in an over-income slot and meets the program specific eligibility requirements (please attach support documentation): (check one) **Yes** **No**

6. Applicant is next on the program waiting list and received no preferential treatment: (check one) **Yes** **No**

7. Applicant is requesting private pay services and has made arrangements for program fees to be paid in advance or through the Payroll Deduction process (Acceptance has been based on a first come/first serve basis, referencing the application date): (check one) **Yes** **No**

8. Are you aware of any appearance of "Conflict of Interest" that may result from the approval of this request? (check one) **Yes-If yes, please explain on the back of this form** **No**

By signing this form, I verify that employee disclosing the above information WAS NOT involved in any part of the selection or processing for the requested HACAP services.

Program Manager (Print)

Signature of Program Manager

Date

Statement 9 competed by the Executive Director or Designee.

9. Request for service has been (check one) **APPROVED** **DENIED**

Signature of Executive Director

Date

Cc: HACAP Employee Personnel File, HACAP Employee, Client File