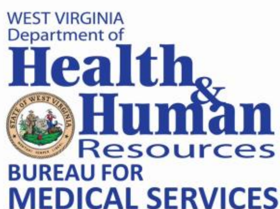


Conflict of Interest Exception Application for Home and Community Based Waiver Services

Agency Name____ NPI#_______________

Location: ____

Date of Exception Application Request: ____________

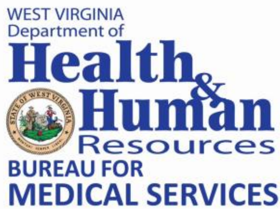
Exception requested for which waiver (Mark one): □ IDDW □ ADW □ TBIW

The above named agency is requesting a Conflict of Interest (COI) Exception testifying that they are the "only willing and qualified entity" in the area to provide both case management and personal attendant services as required by 42 CFR 431.301 (c) (1) (vi), 441.730 (b) and 441.555 (c) Conflict of Interest Federal Requirements (*enrollment in the HCBS authorities, 1915 (c), (i), and (k) triggers COI requirements and note that the COI requirements apply no matter what type of funding stream is used for case management activities)* and will be for the sole benefit of the waiver member. Safeguards must be in place to ensure individual choice and the availability of a "clear and accessible alternative dispute resolution process" when providing both services to the same waiver member.

Conflict of Interest: A "real or seeming incompatibility between one's private interests and one's public or fiduciary duties." This means providers of **Medicaid** home and community-based **services** (HCBS) for the individual, or those who have an **interest** in, or are employed by a provider of HCBS for the individual, must not be the same entity to provide case management or develop the person-**centered service** plan.

This application must be submitted to the UMC/OA prior to BMS' approval before providing services. **Complete the section below if you are the only willing and qualified entity.**

Select boxes below to indicate areas of conflict.	YES	NO
Does the agency provide Direct services (other than case management) including 1915 (c) waiver, or state plan services such as Personal Care Services, OT, PT, and SP?	◯	◯
Does the agency financially benefit from other services a waiver member may receive?	◯	◯
Does the agency have a shared executive director/CEO, Board of Directors, or any financial interest in any entity providing service delivery in home and community-based services including 1915 (c), or State Plan Personal Care Services?	◯	◯



Conflict of Interest Exception Application for Home and Community Based Waiver Services

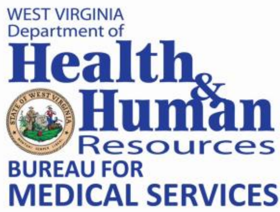
Does the case manager serving the waiver member employed by the agency meet the conditions contained on the "Case Manager Conflict of Interest Assurance" form.	◯	◯

Please describe how your agency will ensure administrative separation of HCB services from case management in the box below. Your description must:

a. Include a basic description of the duties of the direct services supervisor(s) and the case manager supervisor(s). (May attach Job description)
b. Explain how waiver members are given choice of direct services and other natural supports or services offered in the community.
c. Explain how the agency ensures that the case manager is free from influence of direct service providers regarding the waiver members Service Plan/Individualized Program Plan (IPP).
d. Explain how the physical environment of the work site will be separated.
e. Provide a supervisory chart for the agencies.

a. b. c. d. e.

Authorization for this Exception, if granted, is only valid for one year during the annual Service Plan/Individualized Program Plan development and the exception will be reviewed by the OA/UMC. Should another provider become available in the area the OA/UMC will notify the waiver member to update and ensure Freedom of Choice (within policy) of services.



Conflict of Interest Exception Application for Home and Community Based Waiver Services

I certify that I have read and understood all of the questions in this Conflict of Interest Exception Application and that all of the foregoing information and statements submitted are true and correct to the best of my knowledge, and all responses to the questions are full and complete, omitting no material information. The responses include all material information necessary to fully and accurately identify and explain the operations, capabilities and pertinent history of the named firm as well as the ownership, control and affiliations thereof.

I acknowledge and agree that any misrepresentations in the submitted application will be grounds for removal from provider selection forms, of all types; members being transferred to other approved providers; and for initiating action under federal and/or state law concerning false statement, fraud or other applicable offenses.

Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Owner/Administrator/Director Signature Printed Name-Title Date

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Administrative Use Only:

OA/UMC reviewed and verified content of Application and submitted to BMS: ___________________

BMS Approved date: ________________ Expiration date: _________________

Member Medicaid ID Number: ____________________

Agency Notification and copy of form provided Date: ____________________

(This form must be kept in the waiver member's file)