Case Manager Conflict of Interest Assurance Form for Home and Community Based Waiver Services

Name of Case Manager _____

Name of Agency _____ **Provider Number** _____

Circle the HCBS program that applies for this Case Manager:

IDDW ☐ **ADW** ☐ **TBIW** ☐ **PC** ☐

Name of member _____ **Medicaid ID Number** _____

This document must be completed with every member's waiver Service Plan/Individualized Program Plan and stored in the member's file at the case management agency. Failure to have the form on file when audited may result in sanctions.

Assurances	CM Initial
I assure that I do not work for an agency providing Home and Community Based (HCB) services (waiver or personal care services), or if I do, that the agency has applied for or been approved for an exception to conflict-free care coordination requirements.	
I assure that I am not an owner or board member of an agency that provides home and community-based services to the member.	
I assure that I do not provide any HCB services for compensation (regardless of employer).	
I assure that I am not financially responsible for or have a fiduciary relationship with the member (i.e. Guardianship, Conservatorship, Power of Attorney).	

I understand that any false statement, misrepresentation, omission, or concealment in this document may subject me to criminal, civil, or administrative penalties. Under penalty of perjury, I certify that the information I have provided is true, accurate, and complete to the best of my knowledge.

Case Manager Signature _____ Date _____