

KFMC Health Improvement Partners (KFMC)

Personal Conflict of Interest Form

Name _____

Please complete the form below for any conflicts you may have. Distinguish any entry for a family member by preceding it with S (Spouse), D (Dependent) or J (Jointly Held). If you need further information about what must be reported, click on the hyperlinks in each header. This will provide the Federal government's **definition** for each category. You may click "return to form" to get back to this page.

1. **Reportable HEALTHCARE-RELATED assets or sources of income** for myself, my spouse/domestic partner and/or any dependent of the respondent. (If none, notate field with NONE or NA)

Description of Asset (only list assets with > \$10,000 value), i.e., stocks, bonds, annuities, etc.

Description of Income (only list sources producing > \$2500 income) i.e., source of salary, severance, etc.

2. **Reportable HEALTHCARE-RELATED liabilities** for myself, my spouse/domestic partner and/or any dependent of the respondent. (If none, notate field with NONE or NA)

Name of Creditor (include city and state where creditor is located)	Type of liability

3. **Reportable HEALTHCARE-RELATED outside positions** for myself. (If none, notate field with NONE or NA)

Organization (include city and state where organization is located)	Position

4. **Reportable gifts and/or travel reimbursements** for myself. (If none, notate field with NONE or NA)

Source	Description (for travel, include purpose of trip)

This statement contains highly confidential and privileged personal and financial information. KFMC shall maintain its confidentiality. This information is exempt from disclosure under 5 USC §552(b) as commercial or financial information, and personnel or similar files.

5. Conviction / Misuse of Funds

Have you ever been convicted of any felony or a misdemeanor involving misuse/ misappropriation of funds?

☐ Yes (describe below)

☐ No

6. Family or Business Relationship

If you serve as an officer, director, trustee, or key employee of KFMC, do you have a family or business relationship with any other officer, director, trustee or key employee of KFMC?

☐ Yes (identify individual and relationship)

☐ No

☐ Not applicable

Certification of Respondent:

I certify that the statements I have made herein and on all attachments are true, complete, and correct to the best of my knowledge. I agree to update this statement promptly if any of the information changes in such a way that renders the statement incomplete or inaccurate. I agree to recuse myself from any discussion, review, evaluation, consideration, vote or decision regarding any of the entities or individuals disclosed in this statement, with which I or a family member have a financial or other relationship. I will not disclose or use for personal gain any non-public information accessed through any KFMC contract.

Name (print or text) _____ Signature _____

Organization Position _____ Date _____

To Be Completed by COI Compliance Committee Designee

Review Completed By: _____ Date _____

Conflicts of Interest Identified: Yes No If Yes, Actual Potential

Mitigation Strategy:

Copy to Individual: Yes No If Yes, Date _____ Initials _____

Status: Initial Annual Updated

Definitions

Dependent: A son, daughter, stepson or stepdaughter who is either unmarried and under age 21 and living in the filer's house, **or** considered dependent under the U.S. tax code.

Diversified Mutual Fund: A mutual fund that does not have a stated policy of concentrating its investments in one industry, business, or single country other than the United States.

Sector Mutual Fund: A mutual fund that concentrates its investments in an industry, business, single country other than the United States, or bonds of a single state within the United States.

1. Background Information for Reportable Assets

1.A . REPORTABLE ASSETS

Report for yourself, spouse/domestic partner and/or any dependent of the respondent:

- Healthcare-related assets held for investment with a value greater than \$10,000 as of the date of disclosure OR assets held for investment which produced more than \$2,500 in income, including but not limited to:
 - ✓ Healthcare-related assets, such as stocks, bonds, annuities, trust holdings, partnership interests, investment real estate, or a privately-held trade or business;
 - ✓ Healthcare sector mutual funds (report the full name of the fund, not just the general family fund name);
 - ✓ Holdings of healthcare-related self-directed retirement plans, such as 401(k)s, IRAs or SEPs (list each holding);
 - ✓ Defined benefit pension plans provided by a Healthcare-related former employer (include the name of the employer); and,
 - ✓ Type/location of healthcare related real estate.

Do Not Report:

- Federal Government retirement benefits.
- Federal Thrift Savings Plan.
- Certificates of deposit, savings or checking accounts.
- Life Insurance.
- Money market mutual funds and money market accounts.
- Your personal residence.
- Diversified mutual funds, such as ABC Equity, Value Fund or XYZ Large Capital Fund.
- U.S. Federal/State/Local Government bonds, bills, notes, and savings bonds.
- Money owed to you, your spouse/domestic partner and/or dependent by a spouse/domestic partner, parent, sibling, or child.

1.B. HEALTHCARE-RELATED ANNUAL INCOME, ARRANGEMENTS OR AGREEMENTS

Report:

- For yourself/your spouse/domestic partner and/or any dependent of the respondent for all healthcare-related:
 - ✓ Sources of salary,
 - ✓ Severance,
 - ✓ Bonuses,
 - ✓ Fees,
 - ✓ Commissions,
 - ✓ Honoraria, and
 - ✓ Other earned income, arrangements or agreements and other non-investment income such as scholarships, patents, royalties, etc.
- For yourself only:
 - ✓ Continuing participation in an employee pension or benefit plan maintained by a former healthcare-related employer;
 - ✓ A leave of absence in order to perform duties for this present organization; and,
 - ✓ Known future healthcare-related employment, including date you accepted employment offer.

Do Not Report:

- Alimony and child support
- Veterans' benefits Social Security or disability benefits
- Any of the following for spouse/domestic partner and/or any dependent of the respondent:
 - ✓ Continuing participation in an employee pension or benefit plan maintained by a former employer;
 - ✓ A leave of absence to perform duties for this present organization; and,
 - ✓ Known future employment, including date you accepted employment offer.

Return to Form

2. Background Information for Liabilities

Report for yourself, spouse/domestic partner and/or any dependent of the respondent:	Do Not Report:
Loans over \$10,000 from an individual, such as a friend or a business associate who is employed by a Healthcare-related entity or has a business association with a healthcare-related entity.	Loans that you owe to your parent, spouse/domestic partner, sibling and/or any dependent.

Return to Form

3. Background Information for Reportable Outside Positions

Report for Yourself:	Do Not Report:
All healthcare-related positions held at any time during the last 2 years, whether or not you were compensated OR you currently hold that position. Positions include an officer, director, employee, trustee, general partner, proprietor, representative, executor, or consultant of any of the following healthcare-related concerns: <ul style="list-style-type: none">✓ Corporation, partnership, trust, lobbying, or other business entity,✓ Non-profit or volunteer organization, and✓ Educational institution (for instance, teaching hospital)	<ul style="list-style-type: none">• Any position with a:<ul style="list-style-type: none">✓ Religious entity✓ Social entity✓ Fraternal entity• Any position held by your spouse/domestic partner and/or any dependent of the respondent• Any position that you hold as part of your current official duties• Any positions reported in Question 1B

Return to Form

4. Background Information for Gifts or Travel Reimbursement

Report for Yourself:	Do Not Report:
<ul style="list-style-type: none">• All non-employer healthcare, travel-related reimbursements totaling more than \$250 during the reporting period; include where you traveled, the purpose, and date(s) of the trip(s); and,• Any gift(s) from healthcare-related companies with a fair market value totaling more than \$250.	<ul style="list-style-type: none">• Anything received from relatives, the U.S. Government, D.C., state, or local governments;• Bequests and other forms of inheritance;• Gifts and travel reimbursements provided by your organization in connection with your official travel;• Gifts of hospitality (food, lodging, entertainment) at the donor's residence or personal premises; or, anything received by your spouse/domestic partner and/or any dependent of the respondent, totally independent of their relationship to you.

Return to Form