TEXAS Health and Human Services

Form 8623
May 2023

State Long-Term Care Ombudsman Program
Certified Ombudsman Application

Name of Individual:	Local Ombudsman Entity:	
Home Address (Street, City, State and ZIP Code):		
Email Address:	Area Code and Phone No.:	Other Area Code and Phone No.:

Agreement

I request to be designated as a certified ombudsman of the State Long-Term Care Ombudsman Program, as administered by the local ombudsman entity. I agree to:

- abide by ombudsman rules, policies and procedures;
- accept supervision and direction from the managing local ombudsman (MLO) and supervising staff ombudsman;
- submit monthly reports to the MLO;
- attend scheduled ombudsman continuing education;
- avoid a conflict of interest and immediately report any potential conflict to the MLO;
- maintain confidentiality of all information pertaining to residents and complainants; and
- immediately report all criminal charges pending against me, indictments or convictions to the MLO.

Failure to comply with the above items may result in dismissal from the program by either the MLO or State Ombudsman.

My continued certification is dependent upon me:

- completing 18 hours of continuing education each year;
- attending required meetings;
- not having a conflict of interest;
- making regular visits;
- submitting monthly reports; and
- complying with the Ombudsman Certification Training and Ombudsman Policies and Procedures manuals.

I intend to serve a minimum of 12 months. When possible, I agree to provide 30-day notice to the MLO of my intent to leave the program. I understand my certification may be ended by the State Ombudsman for failure to comply with the requirements described above.

A certified ombudsman may email a grievance regarding the State Long-Term Care Ombudsman Program and a decision by the State Ombudsman to ltc.ombudsman@hhs.texas.gov or file a grievance by calling 512-438-4265.

By my signature, I agree to abide by the rules, policies and procedures of the State Long-Term Care Ombudsman Program.

_____ _____
Signature — Certified Ombudsman Applicant **Date**

I state that the above signed individual has received the required training, has completed the required internship, and is qualified to investigate complaints and carry out the activities of a certified ombudsman on behalf of the local ombudsman entity.

I recommend this individual for certification as a ◯ *staff (paid with ombudsman funds)* ◯ *volunteer ombudsman .*

_____ _____
Signature — Managing Local Ombudsman or Designee **Date**

I approve this individual as a certified ombudsman and representative of the Office of the State Long-Term Care Ombudsman.

_____ _____
Signature — State Ombudsman **Date**

Submit by:

- **Mail:** State Long-Term Care Ombudsman Program, P.O. Box 149030, Mail Code W-250, Austin, TX 78714
- **Email:** Ombudsman Program Office Manager or **ltc.ombudsman@hhs.texas.gov**
- **Fax:** 512-438-3233