SAN BERNARDINO COUNTY | Behavioral Health

303 E. Vanderbilt Way San Bernardino | (909) 388-0900
www.SBCounty.gov

RESET

CONFLICT OF INTEREST DISCLOSURE STATEMENT

Initial Disclosure ☐ **Annual Disclosure** ☐ **Updated Disclosure** ☐

Pursuant with California Government Code Sections 1125-1127, County Personnel Rules (1.8 – Conflict of Interest), 42 CFR §438.608 (1)(vii), and Patient Protection Affordable Care Act §6401, all Department of Behavioral Health (DBH) staff must complete this form. The DBH Standard Practice Manual contains the DBH Conflict of Interest Policy (COM0911) outlining rules regarding outside employment, affiliations, relationships that may conflict with your County DBH position, or improperly influence how a person carries out their duties and designated responsibilities. According to this Policy, you are required to disclose in writing any potential conflicts, outside employment, affiliation and/or activity regardless of compensation. Failure to disclose pertinent external employment and/or affiliation/activity, may result in disciplinary action(s).

PLEASE TYPE OR LEGIBLY PRINT RESPONSES

Employee Name	DBH Job Title	DBH Phone #	Employee ID

DBH Program Name	DBH Work Address	City	State	Zip Code

What is the name of your direct DBH Supervisor?	Direct DBH Supervisor's Phone Number

☐ I AM NOT EMPLOYED OR AFFILIATED WITH ANY ***MENTAL HEALTH AND/OR SUBSTANCE USE DISORDER PROGRAM OR ORGANIZATION*** OUTSIDE OF COUNTY DBH ***AND*** AM NOT EMPLOYED BY ANY ENTITY THAT MAY BE CONTRACTED WITH DBH FOR ANY SERVICE (Note: This includes, but is not limited to: managed care plans, educational institution, outreach and engagement, shelter service, information technology or research, foster care and/or rehabilitative services, etc.). **NOTE:** If this box is checked DO NOT enter any employment data; however, report pertinent external activity, relationships, or affiliations on pg. 2

A: Outside Employment. Please list below all current employment or affiliations outside of DBH. Indicate self-employment, if applicable: Is your employer affiliated with DBH? ☐ YES ☐ NO

ENTER INFORMATION FOR 1ST OUTSIDE EMPLOYER

Employer/Organization Name	Address	City	State	Zip Code

Type of Service/Organization	Job Title	Employment Date

Describe the duties you perform at your outside employment position (be specific):

Do(es) you or the agency serve San Bernardino County Medi-Cal beneficiaries? ☐ YES ☐ NO

Indicate client population served: ☐ Children ☐ Transitional Age Youth ☐ Adults ☐ Older Adults

Indicate services you/the agency provide(s): ☐ Mental Health ☐ Substance Use Disorder ☐ N/A

Do you/the agency receive referrals from DBH? ☐ YES ☐ NO

Briefly describe how clients are referred to you/the agency:

Enter your ***DBH*** daily work schedule for BOTH weeks "A" and "B" ("B" week is last day of pay period)

WEEK "A"	START	am/pm	END	am/pm	WEEK "B"	START	am/pm	END	am/pm
Saturday					Saturday				
Sunday					Sunday				
Monday					Monday				
Tuesday					Tuesday				
Wednesday					Wednesday				
Thursday					Thursday				
Friday					Friday				

Enter your exact ***1st outside employer's*** daily work schedule for BOTH weeks "A" and "B" as above

WEEK "A"	START	am/pm	END	am/pm	WEEK "B"	START	am/pm	END	am/pm
Saturday					Saturday				
Sunday					Sunday				
Monday					Monday				
Tuesday					Tuesday				
Wednesday					Wednesday				
Thursday					Thursday				
Friday					Friday				

Are you ever "on-call" for your outside employment? ☐ YES ☐ NO

If you answered YES, explain in detail how this ***WILL NOT*** cause a conflict with your DBH work schedule:

B: EXTERNAL RELATIONSHIPS, AFFILIATIONS OR OTHER ACTIVITIES:

[WRITE OVER TEXT:Please describe any relationships, affiliations or other external activities. This may include, but is not limited to: teaching-providing instructional education, professional consulting, Board/Commission/Committee Membership, political advocacy and/or activity outside of DBH, volunteerism or philanthropy, etc.)]:

I hereby certify that all statements made on this disclosure form are true and complete to the best of my knowledge. I understand that any false statements or relevant omissions may constitute grounds for disciplinary actions, up to and including termination of employment.

Employee ID # **Employee Signature** **Date**

Note: *Supervisors are to place a copy of all signed forms in employee file and send originals or scanned version to Payroll at DBH-AnnualForms@dbh.sbcounty.gov.*

ENTER INFORMATION FOR ADDITIONAL OUTSIDE EMPLOYER(S)				
Employer/Organization Name	Address	City	State	Zip Code
Type of Service/Organization	Job Title		Employment Date	
Describe the duties you perform at your outside employment position (be specific):				
Do(es) you or the agency serve San Bernardino County Medi-Cal beneficiaries? ☐ YES ☐ NO				
Indicate client population served: ☐ Children ☐ Transitional Age Youth ☐ Adults ☐ Older Adults				
Indicate services you/the agency provide(s): ☐ Mental Health ☐ Substance Use Disorder ☐ N/A				
Do you/the agency receive referrals from DBH? ☐ YES ☐ NO				
Briefly describe how clients are referred to you/the agency:				

Enter your ***DBH*** daily work schedule for BOTH weeks "A" and "B" ("B" week is last day of pay period)

WEEK "A"	START	am/pm	END	am/pm	WEEK "B"	START	am/pm	END	am/pm
Saturday					Saturday				
Sunday					Sunday				
Monday					Monday				
Tuesday					Tuesday				
Wednesday					Wednesday				
Thursday					Thursday				
Friday					Friday				

Enter your ***exact additional outside employer's*** daily work schedule for BOTH weeks "A" and "B" as above

WEEK "A"	START	am/pm	END	am/pm	WEEK "B"	START	am/pm	END	am/pm
Saturday					Saturday				
Sunday					Sunday				
Monday					Monday				
Tuesday					Tuesday				
Wednesday					Wednesday				
Thursday					Thursday				
Friday					Friday				

Note: *Supervisors are to place a copy of all signed forms in employee file and send originals or scanned version to Payroll at DBH-AnnualForms@dbh.sbcounty.gov.*