# ATTACHMENT D

# CONFLICT OF INTEREST COMPLIANCE CERTIFICATE

The CMHSP intends to avoid Conflict(s) of interest or the appearance of Conflict(s) of Interest when contracting with Provider. A Conflict of Interest occurs when an individual puts his or her own personal interests in conflict with CMHSP’s interest or creates a situation where CMHSP is at a disadvantage with its funding agencies, regulators, accrediting bodies, customers, network providers, suppliers, or competitors. Thus, the CMHSP reserves the right to determine, at its sole discretion, whether any information received from any source indicates the existence of a Conflict of Interest.

**Conflict of Interest means:**

1. Provider, a sub-contractor, any management officials or affiliated business entities of Provider or sub-contractor; or any employees and agents who will perform services under a proposed or existing Agreement with CMHSP has one or more personal, business or financial interests or relationships which would cause a reasonable individual with knowledge of the relevant facts to question the integrity or impartiality of those who are or will be acting under a proposed or existing CMHSP Agreement; or
2. Provider, a sub-contractor, any management officials or affiliated business entities of Provider or sub-contractor who will perform services under a proposed or existing Agreement with CMHSP is an adverse party to a lawsuit with CMHSP; or
3. Any other facts exist which the CMHSP, in its sole discretion, determines may, through performance of a proposed or existing Agreement with CMHSP, provide Provider or sub-contractor with an unfair competitive advantage which favors the interests of Provider or sub- contractor or any person with whom Provider or sub-contractor has or is likely to have a personal or business relationship; or sub-contractor, any management officials or affiliated business entities of Provider or sub-contractor, or any employees and agents who will perform services under a proposed or existing Agreement with CMHSP refers any portion of the services to a family member.

**Representations as to Conflicts of Interest:**

Answers to the following questions as they apply to Provider, its sub-contractors, its officers, directors, any management officials, any persons that own or control Provider or Provider owns or controls; and any employees or agents who will perform services under this Agreement: Provider will be deemed to have a conflict of interest that must be resolved when Provider answers “yes” to any of the following four (4) questions:

1. Do the persons or entities listed above have a personal, business or financial interest or relationships that relate to the services that will be performed under this Agreement?

☐ YES ☐ NO

1. Has Provider, or any of the persons or entities listed above, been removed from or prohibited from participating in any Federal, State or Local Programs?

☐ YES ☐ NO

1. Are the persons or entities listed above a party to litigation against CMHSP, or representing a party that is in litigation against CMHSP?

☐ YES ☐ NO

1. Does Provider make any referrals to family member when performing services under the contract?

☐ YES ☐ NO

Provider or sub-contractor agrees that if it is awarded a contract, that throughout the life of the Agreement, immediate notification will be provided to the CMHSP if at any time a potential or actual conflict of interest becomes known.

The undersigned hereby affirms that: (check one)

☐ I have read the above statements and declare no conflict of interest exists that would jeopardize the ability of the Contractor or subcontractor to perform under a CMH contract.

☐ A suspected or potential conflict of interest does exist and additional information is attached along with a plan to address the potential conflict of interest.

Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and Title:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Authorized Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_