IOWA HHS

Iowa Department of Health and Human Services

Request for Review of Conflict of Interest and Approval of Outside Employment/Activity

Complete the form and submit to Supervisor for review/processing.

In accordance with the Department of Health and Human Services Employee Handbook and the state of Iowa Employee Handbook rules regarding **Conflicts of Interest and Outside Employment or Activity**, I am requesting approval to obtain/continue outside employment, become engaged in an outside activity or sell goods and services to individuals, associations or corporations subject to the regulatory authority of the Department, which may be in conflict with my duties as an employee of the Department of Health and Human Services. Here is a review of the activity I plan to be involved in and its relationship to my employment and what the Department of Health and Human Services and state of Iowa do.

1. Identify your position title, role, and responsibilities within the Department of Health and Human Services:

Name	Position title
Brief list of current responsibilities	
Where do you work	What are your present hours of work
Supervisor's name	

2. Name the prospective employer, recipient of goods, services, or activity:

Name of organization	Location

3. What will be your role and responsibilities with the proposed recipient organization or outside employer?

Be as specific as possible.

4. Is this outside agency, employer or recipient subject to the regulatory authority of the Department of Health and Human Services? ☐ Yes ☐ No ☐ Unknown

If NO, STOP. You do not need to fill in the remainder of this form. Go to the end of the document, sign, and give to your supervisor for review and processing.

If yes or unknown, proceed with completing all of the information requested on this form.

5. Does this organization do any business with the state of Iowa or Department of Health and Human Services at all? ☐ Yes ☐ No ☐ Unknown

If yes, explain:

6. Is there a contractual or other financial relationship of any kind between the state of Iowa and the outside employer? ☐ Yes ☐ No ☐ Unknown

If yes, explain:

7. What is the employer's or recipient's relationship to the state's or agency's regulatory authority?
☐ None ☐ Unknown ☐ Some, see below

If unknown, please clarify below before submitting this request.

8. Are you requesting to sell goods and services to individuals, associations or corporations subject to the regulatory authority of the Department? ☐ Yes ☐ No ☐ Unknown

If yes or unknown, explain:

9. What period of time do you anticipate serving in this dual capacity?
☐ Ongoing ☐ One time event ☐ See below

From (month/year):	To (month/year):

10. What hours of work will this outside activity or employment require of you?

Provide hours here.

11. Do you or will you receive any form of compensation or benefit from your employment, activities or services? ☐ Yes ☐ No

If you answered yes above, and you will receive some financial compensation, complete the following:	
$ hourly	$ annually
If you answered yes above and will receive some form of compensation other than or in addition to compensation, describe below.	

12. Describe why you feel there is not a conflict of interest between your role and responsibilities as an employee of the Department of Health and Human Services and your role and responsibilities with the outside employer or recipient.

13. Describe why you feel there is not a conflict of interest between the role of the Department of Health and Human Services and the state of Iowa and the outside employer of recipient.

14. Statement of understanding and request:

I recognize that if this request is approved that I will be required to take vacation or other appropriate time off the payroll of the Department of Health and Human Services if the work responsibilities of my outside employer conflict with the hours of work required of me by the Department of Health and Human Services. I understand that taking this time off from work requires supervisor approval. Further, it is understood that no resources of the state of Iowa, e.g., human, material, equipment etc., may be used to support my work for the outside employer.

I realize that if this request is approved, that it is my responsibility to keep my supervisor and Superintendent, Division Administrator or Service Area Manager informed of my outside employment. Furthermore, I realize and accept as my responsibility the requirement to keep the aforementioned management official informed of any change in the outside employer's relationship with the Department of Health and Human Services that may affect my ability to be free from a conflict of interest or appearance of a conflict of interest. I recognize that if I change job duties or positions as an employee of HHS that it may change the status of a conflict of interest or the appearance of a conflict. This change may impact my ability to continue participating in the outside activity or outside employment.

I recognize that the Department, in its sole discretion, has the right to review this activity and to deny my request to participate in outside activity for organizations that are under the regulatory authority of the agency. I recognize that a re-review may be conducted at any time, at the sole discretion of HHS, if there is a change in status of my employment with HHS or a change in the relationship HHS has with an outside organization. I recognize that I can file an appeal with the agency Director, that the Director's decision is final, and that this is not a grievable action.

Approval does not establish a co-employment relationship with any other state agency.

Employee's Name	**Employee's Signature**	**Date**

Recommendation of Appropriate Management Official (Supervisor):

I have considered all relevant facts regarding this request and recommend:

☐ Not Approved ☐ Approved

Supervisor's Signature	**Date**

If the outside agency, employer or recipient is subject to the regulatory authority of the Department, is a vendor of the Department, or serves Department clients, forward to the Department's Executive Secretary for review of past practice prior to Appointment Authority decision.

Recommendation of Appointing Authority:

I have considered all relevant facts regarding this request and recommend based on the attached:

☐ Not approved ☐ Approved based on the following:

Appointing Authority Signature	**Date**

Note: An appeal of this decision must be filed with the HHS Director's Office within 15 days of date of signature.

Forward a copy of the completed form to the requesting employee and to the Department's Executive Secretary.

Approval is subject to the following, if applicable:

You may not be involved with or accept cases of individuals or families that are receiving HHS services.

You may not share HHS confidential information.

You may not recruit of HHS clients.

Acting in the role of guardian, you may not use HHS programs, systems, and files to gain information used as a guardian.

Acting in the role of a CDAC provider for a HHS client, you shall notify your supervisor immediately so that the case may be reassigned.

You may not share any information with outside employer or Board that would provide an advantage in bidding for state of Iowa contracts other than information normally available.

You may not share, with outside employer or Board, any information or knowledge obtained in the course of your HHS employment that would provide an advantage in bidding for state of Iowa contracts.

Other:

The above is not to be considered all-inclusive nor would a determination of approval or denial negate adherence to state and agency rules, policies or procedures.