****

**APPROVED PROVIDER ELIGIBILITY VERIFICATION and INTENT TO APPLY**

**CURRENT PROVIDERS – ALL REVIEW CYCLES**

🟂 **APPLICATION DUE DATE: *see accompanying email***If you have questions, please contact Megan at [**megan@wisconsinnurses.org**](mailto:megan@wisconsinnurses.org)or 608.221.0383, ext. 203 as soon as possible.

🟂 Organizations that intend to reapply for Approved Provider status must complete and return electronically the   
 ‘Approved Provider Eligibility Verification and Intent to Apply’ below.   
 **RETURN TO:** [**megan@wisconsinnurses.org**](mailto:megan@wisconsinnurses.org) **DEADLINE FOR RETURNING:**

|  |  |
| --- | --- |
| **Approved Provider Application Due:** | **Intent Due:** |
| *March 1* | *September 1* |
| *June 1* | *December 1* |
| *September 1* | *March 1* |
| *December 1* | *June 1* |

🟂 **This form should be completed by an individual with the authority and knowledge to attest to the eligibility of   
 this organization to apply for Approved Provider status.**

🟂 You will be notified within two weeks of receipt if your organization is eligible to apply for Approved Provider   
 status. Contact the WNA NPRL at [WNANPRL@wisconsinnurses.org](mailto:WNANPRL@wisconsinnurses.org) with questions.

🟂 **REQUIRED PRE-APPLICATION CALL:**   
Others are welcome, but *the organization Primary Nurse Planner is required to participate in this call.* This is a group call for all Approved Provider applicants in the current renewal cycle. You will be sent an Outlook appointment for this call.

🟂 If you do not intend to submit a renewal application for Approved Provider status, please contact Megan at [**megan@wisconsinnurses.org**](mailto:megan@wisconsinnurses.org)or 608.221.0383, ext. 203 as soon as possible.

**Section 1. DEMOGRAPHICS**

|  |  |
| --- | --- |
| **Organization:** |  |
| **Mailing Address:** |  |
| **Contact Person:** |  |
| **Title/Position:** |  |
| **Phone:** |  |
| **Email Address:** |  |

*In 2018, WNA CEAP implemented a tiered review fee structure for Approved Provider applications. With an ‘X’ in the first column, please identify below the most appropriate tier (1, 2, or 3) for your organization, and an invoice will be sent for the application review fee. Contact Megan at* [***megan@wisconsinnurses.org***](mailto:megan@wisconsinnurses.org)*or 608.221.0383, ext. 203 should you have questions.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **X** |  | **TIER** | **REVIEW FEE** | **DESCRIPTION** |
|  | **Single Agency Provider** | 1 | $1,650 | A single agency provider may be part of a larger corporate system. However, the single agency/hospital is only providing continuing education for the agency/hospital named in the application. A single agency/hospital provider does not act as the provider of continuing education for multiple agencies/hospitals. |
|  | **System Provider  (2-5 facilities)** | 2 | $1,800 | A system provider is a multi-agency/hospital/health care system providing health care services through two or more agencies/hospitals that share a common mission and/or purpose. The system is a corporation with a central administration providing services to all of the agencies/hospitals within the corporate structure. A system provider has in place at the corporate level a centralized staff development and/or continuing education department responsible for planning and implementing a system wide continuing education program. All agencies/hospitals in system must be named in the application and remain unchanged throughout approval period. |
|  | **Large System Provider  (6 or more facilities)** | 3 | $2,000 | A large system provider is a multi-agency/hospital/health care system providing health care services through six or more agencies/hospitals that share a common mission and/or purpose. The system is a corporation with a central administration providing services to all of the agencies/hospitals within the corporate structure. A system provider has in place at the corporate level a centralized staff development and/or continuing education department responsible for planning and implementing a system wide continuing education program. All agencies/hospitals in system must be named in the Application and remain unchanged throughout approval period. |

**Section 2. NURSE PLANNERS**

|  |  |
| --- | --- |
| All Nurse Planners are currently licensed Registered Nurses with a baccalaureate degree or higher in nursing. | |
|  | YES |
|  | NO – Please stop and contact the WNA NPRL to discuss eligibility. |

|  |  |
| --- | --- |
| Identify the PNP responsible for adhering to ANCC/WNA CEAP criteria in the provision of continuing nursing education. | |
| Name and Credentials: |  |
| Title/Position: |  |
| Phone: |  |
| Email Address: |  |

|  |  |
| --- | --- |
| Nurse Planners are (1) actively involved in planning all CNE activities from start to finish; (2) knowledgeable about the nursing CE process; and (3) meet the qualifications to hold this position. | |
|  | YES |
|  | NO – Please stop and contact the WNA NPRL to discuss eligibility. |

**Section 3. REGIONAL TARGET MARKET**

During the past year, did the organization promote/market/advertise more than half of its learning activities to nurses within the states of DHHS Region 5 (WI, IL, IN, MI, OH, ND, SD, IA, MO, KY, WV, PA)?  
(*For additional information, please refer to the map at* [*http://www.hhs.gov/about/regionmap.html*](http://www.hhs.gov/about/regionmap.html)*)*

|  |  |
| --- | --- |
|  | YES – Proceed to section 4. |
|  | NO – Please stop and contact the WNA NPRL to discuss eligibility. |

*Note: If you primarily offer on-line programming, please contact the WNA NPRL to discuss eligibility.*

**Section 4. OPERATIONS**

The organization has a clearly defined ‘provider unit‘ or department administratively and operationally responsible for continuing nursing education. An Approved Provider Unit (APU) is defined structurally and operationally as the members of the organization who support the delivery of Continuing Nursing Education activities.

|  |  |
| --- | --- |
| My provider unit is: | |
|  | A free-standing organization whose purpose is only to offer continuing education programs for nurses(single- |
| focused organization) |
|  | Part of an organization that does other things besides offer continuing education programs for nurses (multi- |
| focused organization) |

|  |  |
| --- | --- |
| If your organization is multi-focused, is there a separate, clearly defined ‘provider unit’ administratively and operationally responsible for planning, implementing, and evaluating continuing nursing education? | |
|  | YES |
|  | NO – Please stop and contact the WNA NPRL to discuss eligibility. |

Is the organization in compliance with all applicable federal, state, and local laws and regulations that affect the organization’s ability to meet ANCC/WNA CEAP criteria and requirements?

|  |  |
| --- | --- |
|  | YES |
|  | NO – Please stop and contact the WNA NPRL to discuss eligibility. |

**Section 5. COMMERCIAL INTEREST**

**The following section is intended to collect information about the applicant organization’s corporate structure. Some organization types are *automatically* exempt from ANCC’s definition of a commercial interest**, **including:**

* Blood banks
* Constituent Member Associations
* Diagnostic laboratories
* Federal Nursing Services
* For-profit and not for profit hospitals
* For-profit and not for profit nursing homes
* For profit and not for profit rehabilitation centers
* Group medical practices
* Government organizations
* Health insurance providers
* Liability insurance providers
* National nursing organizations based outside the United States
* Non-health care related companies
* Specialty Nursing Organizations
* A single-focused organization\* devoted to offering continuing nursing education   
  (\*A single-focused organization exists for the single purpose of providing CNE.)

|  |
| --- |
| **NOTE: 501c organizations are not *automatically* exempt.** The ANCC Accreditation Program requires 501c organizations to be screened for eligibility. |

The organization is exempt from ANCC’s definition of a commercial interest.

|  |  |  |
| --- | --- | --- |
|  | YES | |
| Identify the organization’s exemption type from the list above: |  |
| **You have completed the ‘Approved Provider Eligibility Verification and Intent to Apply’. Continue to Section 7.** | |

|  |  |  |  |
| --- | --- | --- | --- |
|  | NO – The following questions must be answered, so WNA CEAP can assess the organization's eligibility to apply. | | |
| Does the applicant organizationproduce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients? | | |
|  |  | YES – If yes, the organization is **not eligible** to apply for Approved Provider status. |
|  |  | NO – Proceed to next question. |
| Is the applicant organization owned or controlled by a multi-focused organization that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients? | | |
|  |  | YES – Proceed to next question. |
|  |  | NO – **You have completed the ‘Approved Provider Eligibility Verification and Intent to Apply’. Continue to Section 7.** |
| Is the applicant organization a separate and distinct entity from the multi-focused organization? | | |
|  |  | YES – Proceed to next SECTION. |
|  |  | NO – The organization is **not** a separate and distinct entity from the multi-focused organization, and the organization is **not eligible** to apply for Approved Provider status. |

**Section 6. COMMERCIAL INTEREST CONTINUED**

Does the multi-focused organization that owns the applicant organization have 501(c) (non-profit) status?

|  |  |
| --- | --- |
|  | YES |
|  | NO |

**If yes**, does the company that owns the applicant organization advocate for a commercial interest (as defined by the ANCC Accreditation Program?)

|  |  |
| --- | --- |
|  | YES – OR, if you are not sure, please describe the relationship the company that owns the applicant organization has with a commercial interest and the types of work said company does for or on behalf of a commercial interest that might be considered advocacy. |
|  |  |

|  |  |
| --- | --- |
|  | NO – Complete the next question. |

Is any component of the multi-focused organization an entity that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?

|  |  |  |
| --- | --- | --- |
|  | YES | |
|  | 1. Please describe the health care goods or service consumed by or used on patients and the role of the entity in producing, marketing, re-selling or distributing those healthcare goods or services. | |
|  |  |  |

|  |  |
| --- | --- |
|  | 1. Contact the WNA NPRL to discuss next steps. |

|  |  |
| --- | --- |
|  | NO – Complete the next question. |

**Section 6. STATEMENT OF UNDERSTANDING**

I attest, by my signature below, that I am duly authorized by [insert your organization name here] to apply to WNA CEAP for Approved Provider status under the American Nurses Credentialing Center (ANCC) accreditation criteria and to make the statements herein. On behalf of my organization, I have read the Approved Provider eligibility requirements and criteria. I understand that my organization is subject to all eligibility requirements and criteria as an Approved Provider. I understand that becoming an Approved Provider depends on successfully meeting eligibility requirements and criteria, and maintaining Approved Provider standing is dependent upon continued compliance.

On behalf of my organization, I expressly acknowledge and agree that information accumulated through the approval process may be used for statistical, research, and evaluation purposes and that anonymous and aggregate data may be released to third parties. Otherwise, all information will be kept confidential and shall not be used for any other purposes without my organization’s permission.

On behalf of my organization, I hereby certify that the information provided on this document is true, complete, and correct. I further attest that this organization will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that our organization will notify WNA CEAP promptly if, for any reason while this application is pending or during any approval period, our organization does not maintain compliance. I understand that any misstatement of material fact submitted on, with or in furtherance of this application for Approved Provider status shall be sufficient cause for WNA CEAP to deny, suspend or terminate our organization’s Approved Provider status and to take other appropriate action against the organization.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Primary Nurse Planner Name and Credentials:** | | |  | **Date:** |  |
| **Position/Title:** |  | | | |

**Electronic Signature:**

|  |  |
| --- | --- |
|  | By placing an ‘X’ in this box, I attest that the above is my electronic signature. |