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

**ALL APPROVED PROVIDER APPLICANTS – ALL REVIEW CYCLES**

Organizations that intend to apply or re-apply for Approved Provider status must complete and return this ‘Approved Provider Eligibility Verification and Intent to Apply.’ **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.**

🟂 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.

* **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.

🟂 **RETURN THIS COMPLETED FORM 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* |

🟂 You will be notified within approximately two weeks of receipt if your organization is eligible to apply for Approved Provider status. Contact WNA’s Accredited Approver Program Director (AAPD) at [WNANPRL@wisconsinnurses.org](mailto:WNANPRL@wisconsinnurses.org) with questions.

🟂 **REQUIRED PRE-APPLICATION CALL:** Others are welcome, but *the organization’s Primary Nurse Planner is required to participate in this call with WNA’s Accredited Approver Program Director.*  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.* ***By placing an ‘X’ in the first column, identify below the tier (1, 2, or 3) for your organization, and an invoice will be sent for the application review fee.*** *If needed, a description of each tier is on page 5.*

|  |  |  |  |
| --- | --- | --- | --- |
| **CHECK (“X”) the box for your organization’s provider type BELOW** | **PROVIDER TYPE** | **TIER** | **REVIEW FEE** (effective 7-1-23) |
|  | Single Agency Provider | 1 | $1,750 |
|  | System Provider (2-5 facilities) | 2 | $1,900 |
|  | Large System Provider (6 or more facilities) | 3 | $2,100 |

*Contact Megan at* [***megan@wisconsinnurses.org***](mailto:megan@wisconsinnurses.org) *or 608.221.0383, ext. 203 should you have questions.*

**Section 2. PRIMARY NURSE PLANNER (PNP) and NURSE PLANNERS (“NPs”)**

|  |  |
| --- | --- |
| Identify the Primary Nurse Planner (PNP) responsible for all aspects of the Provider Unit, including adhering to ANCC/WNA CEAP criteria in the provision of nursing continuing professional development (NCPD). | |
| Name and Credentials: |  |
| Title/Position: |  |
| Phone: |  |
| Email Address: |  |

1. Will the Primary Nurse Planner be assisted by Nurse Planners to carry out the work of the Provider Unit?

|  |  |
| --- | --- |
|  | YES – List names and all credentials for each Nurse Planner listed in question 4 below. |
|  | NO |

1. Are all Nurse Planners currently licensed Registered Nurses with a baccalaureate degree or higher, in nursing.

|  |  |
| --- | --- |
|  | YES |
|  | NO – Please stop and contact the WNA Accredited Approver Program Director (AAPD) to discuss eligibility. |

1. Are Nurse Planners (1) directly and actively involved in planning, implementing, and evaluating all NCPD activities; (2) knowledgeable about developing education for adult learners?

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

1. List all Nurse Planner Names and all credentials here if the educational unit has nurse planners.

|  |  |
| --- | --- |
| Nurse Planner Name | All credentials of the Nurse Planner Listed |
|  |  |

**3. REGIONAL TARGET MARKET**

During the past year, did the organization promote/market/advertise more than half of its learning activities to nurses within its own region? (<https://www.hhs.gov/about/agencies/iea/regional-offices/index.html>)

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

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

**Section 4. OPERATIONS**

1. 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 AAPD to discuss eligibility. |

1. Has the organization been in operation (functioning by using the WNA CEAP/ANCC criteria with all essential provider unit personnel in place) for a minimum of six months prior to applying for Approved Provider status?

|  |  |  |
| --- | --- | --- |
|  | YES – If yes, provide the date the organization became operational: |  |
|  | NO – Please stop and contact the WNA AAPD to discuss eligibility. | |

1. Has the organization assessed, planned, implemented, and evaluated at least three separate educational activities, within the past 12 months, provided at separate and distinct events that:

|  |  |  |
| --- | --- | --- |
|  | YES | |
|  | Directly involved a designated Nurse Planner; |
|  | Adhered to ANCC/WNA CEAP criteria; |
|  | Were approved by the WNA CEAP Committee or another ANCC-accredited approver within the past year; |
|  | Were at least one contact hour in length (contact hours may or may not have been offered); and |
|  | Were not jointly-provided (new applicants only) |
|  | NO – Please stop and contact the WNA AAPD to discuss eligibility. | |

**Section 5. ELIGIBILITY BASED ON PRIMARY BUSINESS OF ORGANIZATION**

**The following section is intended to collect information about the applicant organization’s corporate structure. Ineligible companies cannot apply to be a WNA Approved Provider. Some organization types are exempt from the definition of an “ineligible company,”** **including:**

* Blood banks
* Constituent Member Associations
* Diagnostic laboratories that do not sell proprietary products
* 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 – an organization that exists only to offer nursing continuing professional development [NCPD] opportunities

|  |
| --- |
| **NOTE: 501c organizations are not *automatically* exempt.** |

We believe our organization is exempt from the definition of an “ineligible company” because it is one of the entities listed above.

|  |  |  |
| --- | --- | --- |
|  | 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 6.*** | |

|  |  |  |
| --- | --- | --- |
|  | NO – The following questions must be answered, so WNA CEAP can assess the organization's eligibility to apply. | |
| Does the applicant organizationproduce, market, sell, re-sell, or distribute health care products used on or by patients? | |
|  | YES – If yes, the organization is **not eligible** to apply for Approved Provider status. ***Contact the WNA AAPD.*** |
|  | NO – Proceed to next question. |
| Is the applicant organization owned or controlled by a parent or sister organization that produces, markets, sells, re-sells, or distributes health care products used on or by patients? | |
|  | YES – Proceed to next question. |
|  | NO – **You have completed the ‘Approved Provider Eligibility Verification and Intent to Apply’. *Continue to Section 6.*** |
| Is the applicant organization a separate and distinct entity from the parent or sister organization? | |
|  | YES – **Contact the WNA AAPD for additional assessment of your company’s eligibility** prior to completing this form. |
|  | NO – The organization is **not** a separate and distinct entity from the parent or sister organization, and the organization is **not eligible** to apply for Approved Provider status. |

**Section 6. STATEMENT OF UNDERSTANDING**

I attest, by my signature below, that I am duly authorized by [insert your organization name here], (henceforth in this document, “my organization”) 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.

|  |  |  |  |
| --- | --- | --- | --- |
| **Name and Credentials:** |  | **Date:** |  |
| **Position/Title:** |  | | |

**Electronic Signature:**

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

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**FOR OFFICE USE ONLY**

**Findings:**

|  |  |
| --- | --- |
|  | This organization is **eligible** to apply/re-apply to be a WNA Approved Provider. |
|  | This organization is **not eligible** to apply/re-apply to be a WNA Approved Provider. |
|  | This organization is **not eligible** and should be referred to ANCC. Reason: |

|  |  |
| --- | --- |
| **Reviewed by:** |  |
| **Date:** |  |

**Electronic Signature:**

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

|  |  |  |  |
| --- | --- | --- | --- |
| **PROVIDER ORGANIZATION TIERS** | | | |
| **Single Agency Provider** | 1 | **$1,750** | * The single agency/hospital only provides nursing continuing professional development activities for the individual agency/hospital named in the application. * A single agency/hospital provider does not act as the provider of continuing education for multiple agencies/hospitals. * (A single agency provider may be part of a larger corporate system but not act as a Provider to other organizations in that system.) |
| **System Provider  (2-5 facilities)** | 2 | **$1,900** | * 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 the agencies/hospitals within the corporate structure. * A system provider usually has in place at the corporate level a centralized staff development and/or 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 | **$2,100** | * 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 generally 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. |