NEW JERSEY STATE NURSES ASSOCIATION

Approved Provider Eligibility Verification Form

New Jersey State Nurses Association is accredited as an approver of continuing nursing education with distinction by the American Nurses Credentialing Center's Commission on Accreditation.

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New Jersey State Nurses Association
Approved Provider Eligibility Verification

Section 1: Demographic Data

Organizations interested in submitting an application for approval as an Approved Provider must complete the Eligibility Verification and meet all Eligibility Requirements. Verification forms received from organizations that do not meet Eligibility Requirements will be rejected without substantive review.

_____
Name of Organization

_____
Street Address

_____
City State Zip/Postal Country

Identify Organization Type:

- ☐ Constituent Member Associations of ANA
- ☐ College or University
- ☐ Healthcare Facility
- ☐ Health - Related Organization
- ☐ Multidisciplinary Educational Group
- ☐ Professional Nursing Education Group
- ☐ Specialty Nursing Organization

_____
Primary Nurse Planner: Name and Credentials

_____
Title/Position

_____
Telephone Number E-mail Address

- Has the applicant organization ever been **denied accreditation by ANCC** or had its accreditation status suspended or revoked?

  ☐ Yes ☐ No

  If yes, please provide the following information:
  Date: _____ Action: ☐ Denial ☐ Suspension ☐ Revocation
  Briefly describe below:

- Has the applicant organization ever been **denied approval** by or had approval suspended or revoked for an individual activity or a provider application by NJSNA?

  ☐ Yes ☐ No

If yes, please provide the following information:
Date: _____ Action: ☐ Denial ☐ Suspension ☐ Revocation
Briefly describe below:

- Has the applicant organization ever been **denied approval** by or had approval suspended or revoked for an individual activity or a provider application by another ANCC Accredited Approver (state or national)?

  ☐ Yes ☐ No

If yes, please provide the following information:
Date: _____ Action: ☐ Denial ☐ Suspension ☐ Revocation
Briefly describe below:

Section 2: Nurse Planners

- All Nurse Planners are currently licensed registered nurses with baccalaureate degrees or higher in nursing.

  ☐ Yes ☐ No

- If applicant organization has multiple nurse planners, a primary nurse planner is utilized as the contact for the ANCC Accredited Approver Unit and ensures compliance with the ANCC/ NJSNA criteria.

  ☐ Yes ☐ No

  If yes, provide Primary Nurse Planner's Name and Credentials below:

- The Nurse Planner is an active participant in the planning, implementing and evaluation process of ***each*** continuing education activity.

  ☐ Yes ☐ No

Please list the names and credentials of all current nurse planners:

Nurse Planner Name	Credentials

Section 3: Regional Target Market

- During the past year, did the applicant organization promote/market/advertise more than half of its learning activities to nurses ***within*** the states of NJ, NY, Puerto Rico, and the Virgin Islands? (For region information, refer to **http://www.hhs.gov/about/regions**)

  ☐ Yes **If yes**, proceed to section 4

  ☐ No **If no**, the applicant organization is not eligible for Approved Provider status, but may be eligible for Accredited Provider status. (For more information, refer to **www.nursecredentialing.org/Accreditation**)

Section 4:

The applicant organization must answer the following questions and provide any additional required information.

- The applicant has been operational for 6 months using the ANCC/NJSNA Criteria.

☐ Yes **If <u>yes</u>**, list the date the applicant organization became operational: _____

☐ No **If <u>no</u>**, the applicant organization is **<u>not</u>** eligible for Approved Provider status

- The applicant has assessed, planned, implemented, and evaluated at least three separate educational activities, within the past 12 months, provided at separate and distinct events:
  - with the direct involvement of the Nurse Planner;
  - that adhere to the ANCC Accredited Approver Criteria;
  - each learning activity must be at least 1 hour (60 minutes) in length. Contact hours may or may not have been offered;
  - and were **<u>not</u>** joint provided (new applicants only).

☐ Yes ☐ No

- Applicant organization is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the delivery of CNE.

☐ Yes ☐ No

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 Nurses Organizations based outside the United States,
- Non-health care related companies, and
- Specialty Nursing Organizations
- A single-focused organization* devoted to offering continuing nursing education

* The <u>Single-Focused Organization</u> exists for the single purpose of providing CNE.

NOTE: 501-C organizations are <u>not</u> *automatically* exempt. The ANCC Accreditation Program requires 501-C organizations to be screened for eligibility.

☐ **Checking this box identifies the applicant organization as exempt from ANCC's definition of a commercial interest. Identify the applicant organization's exemption type from section 2 above and enter it below:**

<u>If you checked the box above, then you have completed this questionnaire</u> and should proceed to Section 8.

Section 6 - Only complete this section if applicant organization is <u>NOT</u> exempt

☐ **Checking this box identifies the applicant organization as <u>NOT</u> exempt from the ANCC Accreditation Program's definition of a commercial interest.** The following questions must be answered, so NJSNA can assess the applicant organization's eligibility.

- Does the applicant organization produce, market, re-sell, or distribute health care goods or services consumed by, or used on, patients?
  - ☐ Yes **<u>If yes</u>**, the organization is **<u>not</u>** eligible for Approved Provider status
  - ☐ No **<u>If no</u>, complete the next bulleted question.**

- Is the applicant organization owned or controlled by a multi-focused organization (MFO*) that produces, markets, re-sells, or distributes health care goods or services consumed by, or used on, patients?
  - ☐ Yes **<u>If yes,</u> complete the next bulleted question**.
  - ☐ No **<u>If no,</u> you have completed this questionnaire and should proceed to Section 8.**

- Is the applicant organization a separate and distinct entity from the MFO*?
  - ☐ Yes **<u>If yes</u>, continue to section 7**
  - ☐ No **<u>If no,</u>** the organization is **<u>NOT</u>** a separate and distinct entity from the MFO* then the organization is **<u>NOT</u>** eligible for Approved Provider status.

* <u>Multi-Focused Organization (MFO)</u> is an organization that exists for more than providing continuing nursing education.

Section 7

- Does the multi-focused organization that owns the applicant organization have a

501-C Non-profit Status?

☐ Yes ☐ No

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

☐ Yes **If yes**, or you are not sure, please describe (in the space provided below) the relationship the company that owns your organization has with a commercial interest and the types of work the company that owns your organization does for or on behalf of a commercial interest that might be considered advocacy.

☐ No

Does 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 **If yes**, please describe (in the space provided below) 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.

☐ No **If no**, **you have completed this questionnaire, proceed to Section 8**.

If yes, please complete the ***Approved Provider Eligibility Commercial Interest Addendum*** and submit with this Form.

Section 8: Statement of Understanding

(Please insert **Name of Organization** in the spaces provided below):

I attest, by my signature below, that I am duly authorized by _____ to submit this application as an approved provider offered by the American Nurses Credentialing Center (ANCC) through Accredited Approvers and to make the statements herein. On behalf of _____, I have read the approved provider eligibility requirements and criteria. I understand that _____ 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 _____, 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 _____'s permission.

On behalf of _____, I hereby certify that the information provided on and with this application is true, complete, and correct. I further attest, by my signature on behalf of _____, that _____ will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that _____ will notify NJSNA promptly if, for any reason while this application is pending or during any approval period, _____ 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 NJSNA to deny, suspend or terminate _____'s approved provider status and to take other appropriate action against _____.

(Applications received without a signature incur a delay in processing which will cause a delay in the review of the approval application.)

An “X” in the box below serves as the electronic signature of the individual completing this form and attests to the accuracy of the information contained.

☐ **Electronic Signature (Required)** **Date** _____

_____

Completed By: Name and Title

Please return the completed Eligibility Verification Form and if necessary, the Approved Provider Eligibility Commercial Interest Addendum to: New Jersey State Nurses Association; Attn: Kortnei Jackson; 1479 Pennington Road; Trenton, NJ 08618; or via email @ KJackson@njsna.org

New Jersey State Nurse Assocation
Approved Provider Eligibility
Commercial Interest Addendum

Applicants should <u>only</u> complete this addendum if directed to do so by the approved provider eligibility verification form or by the Accredited Approver.

_____
Name of Applicant Organization

_____
Primary Point of Contact: Name and Credentials

_____
Title/Position

_____
Telephone Number E-mail Address

Please answer the following questions to assist in verifying the applicant organization's eligibility.

Are there organizational and procedural safeguards ('corporate firewalls') in place to ensure that the applicant organization is separate from any commercial interest listed on the approved provider eligibility verification form?

☐ Yes
☐ No **If no, the organization is <u>not</u> eligible for approval as a provider**

<u>Multi-Focused Organization (MFO)</u> is an organization that exists for more than providing continuing nursing education

<u>If yes</u>, complete the following:

1. Are the applicant organization's offices physically separate from the MFO or component of the MFO?

   ☐Yes ☐ No

2. Is the applicant organization a separate legal entity from the MFO and components of the MFO?

   ☐Yes ☐ No

3. Does the applicant organization have a separate federal tax identification number from the MFO and components of the MFO?

☐ Yes ☐ No

4. Do any members of the MFO or component of the MFO have the ability to do any of the following:

A) Require or suggest information relating to the content of the applicant organization's CE activities:
☐ Yes ☐ No

B) Review of activity content;

☐ Yes ☐ No

C) Suggest faculty for an activity;

☐ Yes ☐ No

D) Recommend either educational format or methods of evaluation.

☐ Yes ☐ No

5. Does the applicant organization 'share' services with the MFO or component of the MFO?

☐ Yes ☐ No

If yes, please list services that are 'shared' and describe (in the space provided below) how this is accomplished.

6. Please describe (in the space provided below) any additional information that ensures the applicant organization is independent of a commercial interest's ownership and control.

7. Are the applicant organization's servers, phone and fax lines, email addresses, web domains, if any, and other information technology infrastructures separated in any way from the MFO or component of the MFO?

☐ Yes ☐ No

8. Can employees of the MFO or component of the MFO access electronic information concerning the applicant organization's CE activities stored on the applicant organization's computers?

☐ Yes ☐ No

If yes, please explain in the space provided below:

9. In connection with the applicant organization's finances, which of the following does the applicant organization do?

A. Maintain own budget ☐Yes ☐ No

B. Conduct own grant reconciliation ☐ Yes ☐ No ☐ N/A

C. Maintain own Profit/Loss statement(s) ☐ Yes ☐ No

D. Maintain own billing, accounts receivable and payable ☐ Yes ☐ No

E. Issue own W-9 forms ☐ Yes ☐ No

10. Is the applicant organization the employer of record for its own employees?

☐ Yes ☐ No

11. Does the applicant organization have any written policies addressing its independence in the manner in which its CE activities are planned and published?

☐ Yes ☐ No

12. Does the applicant organization collaborate on any projects with companies that meet the ANCC Accreditation Program's definition of a commercial interest?

☐ Yes ☐ No

13. Please describe (in the space provided below) anything else that assures independence of the applicant organization in connection with its governance structure.

Please provide a diagram, in a separate document, showing the applicant in relation to the MFO and/or component of the MFO, as applicable. Please indicate which component of the MFO meets the definition of a commercial interest.

If there are any written policies regarding assuring the independence of the applicant organization from the MFO or component of the MFO, please provide copies for NJSNA.

An "X" in the box below serves as the electronic signature of the individual completing this Approved Provider Eligibility Commercial Interest Addendum and attests to the accuracy of the information given above.

☐ **Electronic Signature (Required)** **Date** _____

_____

Completed By: Name and Title

Please return this completed Addendum to: New Jersey State Nurses Association; Attn: Kortnei Jackson; 1479 Pennington Road; Trenton, NJ 08618; or via email @ KJackson@njsna.org