**Mississippi Nurses Foundation**

**AA/AP-EV**

**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 Point of Contact: Name and CredentialsTitle/Position\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Number E-mail Address  |

**Section 2: Nurse Planners**

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

      Yes      No (If no, applicant is not eligible to proceed)

* If an 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 accreditation criteria.

     Yes      No (If no, applicant is not eligible to proceed)

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

* A Nurse Planner from the list below is an active participant in the planning, implementing and evaluation process of ***each*** continuing education activity.

     Yes      No (If no, applicant is not eligible to proceed)

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 your region and the states contiguous to your region? (For region information, refer to [**http://www.hhs.gov/about/agencies/iea/regional-offices/index.html**](http://www.hhs.gov/about/agencies/iea/regional-offices/index.html))

      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 **https://www.nursingworld.org/organizational-programs/accreditation/ncpd/**)

**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 Accreditation Criteria.

      Yes **If yes**, list the date the applicant organization became operational:

      No **If no**, the applicant organization is **not** 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 one of the Nurse Planners listed above;
	+ that adhere to the ANCC Accreditation Program 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 **not** joint provided (new applicants only).

      Yes       No

* The applicant organization is in compliance with all applicable Federal, State, and Local laws and regulations that apply to the delivery of NCPD.

       Yes       No

**Section 5: Ineligible Company**

**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 an ineligible company** **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 nursing continuing professional development.

\* The Single-Focused Organization exists for the single purpose of providing NCPD.

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

     **An "X" on this line identifies the applicant organization as exempt from ANCC’s definition of a ineligible company. Identify the applicant organization's exemption type from section 2 above and enter it here:**

**If you checked the box above, then you have completed this questionnaire** and should proceed to Section 8.

**Section 6 - Only complete this section if applicant organization is not exempt.**

     **An "X" on this line identifies the applicant organization as not exempt from the ANCC Accreditation Program’s definition of an ineligible company.** The following questions must be answered, so the Mississippi Nurses Foundation can assess the applicant organization's eligibility.

**NOTE:** Companies whose primary business is producing, marketing, re-selling, or distributing healthcare products used by or on patients are ineligible for ANCC accreditation per the Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company.

1. Does your organization, or a part of your organization, produce, market, re-sell, or distribute healthcare products used by or on patients?

     Yes

     No

1. Does your organization advocate for an ineligible company?

     Yes

     No

1. Does your organization have a non-primary business function that includes producing, marketing, reselling, or distributing of healthcare products used by or on patients and/or advocating for, or on behalf of an ineligible company?

     Yes

     No

3A. If you answered YES to Q3, is the nonprimary business function, which led to answer yes, conducted by a separate legal entity with separate management and staff from the entity applying for accreditation?

     Yes

     No

3B. If you answered NO to Q3A, describe the organizational and procedural safeguards that are in place to ensure that the CME entity is separate from any ineligible company within the larger corporate structure of your organization.

     Yes

     No

3C. If you answered NO to Q3A, upload an organizational chart that includes the names of the persons in each position to depict these safeguards.

     Yes

     No

1. Does your organization have a parent company that:

**(A "parent company" is a separate legal entity that owns or fiscally controls an organization.)**

4A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or

     Yes

     No

4B. advocates for, or on behalf of, an ineligible company?

     Yes

     No

1. Does your organization have a sister company that:

**(A "sister company" is a separate legal entity which is a subsidiary of the same parent company that owns or fiscally controls an organization.)**

5A. produces, markets, re-sells, or distributes healthcare products used by or on patients, and/or…

     Yes

     No

5B. advocates for, or on behalf of, ineligible companies?

     Yes

     No

1. If you answered YES to Q5, does your organization share management, employees, or governance structure with the sister company?

     Yes

     No

1. If you answered YES to Q5, are any owners, employees, or agents of the sister company involved in the planning, development, or implementation of educational content?

     Yes

     No

1. If you answered YES to Q5, does the sister company control or influence, in whole or in part, the operations of your organization?

     Yes

     No

**NOTE:** If you answered YES to Q3-8 your organization would likely be defined by the ACCME Standards for Integrity and Independence in Accredited Continuing Education as an ineligible company

**Section 7: Statement of Understanding**

I attest, by my signature below, that I am duly authorized by (Insert name of organization) 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 (Insert name of organization), I have read the approved provider eligibility requirements and criteria. I understand that (Insert name of 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 (insert name of 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 (insert name of organization)’s permission.

On behalf of (insert name of organization), 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 (insert name of organization), that (insert name of organization) will comply with all eligibility requirements and approval criteria throughout the entire approval period, including all reapplication periods for maintaining approval, and that (insert name of organization) will notify the Mississippi Nurses Association promptly if, for any reason while this application is pending or during any approval period, (insert name of 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 the Mississippi Nurses Foundation to deny, suspend or terminate (insert name of organization)’s approved provider status and to take other appropriate action against (insert name of organization).

*(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**