Diabetes Education
Accreditation Program

AADE American Association of Diabetes Educators

AADE Application For Reaccreditation

By proceeding with this application I affirm the following:

1. I have read and understand any updated versions of the National Standards, and Accreditation Program policies and procedures.
2. The administrator responsible for the program verifies that the information included in this application is true and accurate.
3. It is the responsibility of the program coordinator to notify appropriate entities in order to receive reimbursement.
4. I understand, and agree to, the release of data to Centers for Medicare and Medicaid Services as required.
5. I agree to indemnify AADE against any damage or injury to DSMT participants.

Name of person completing application:	
Title:	
Date Application Submitted:	

PROGRAM DEMOGRAPHICS

Program Contact and Mailing Information	
Name of Program:	
Program ID#:	
Street	
City:	
State:	
Zip Code:	
Telephone:	
Facsimile:	
Name of Sponsoring/Affiliate Organization:	

Street address:	
City:	
State:	
Zip code:	
Name of Administrator:	
Title:	
Organization type:	☐ Durable Medical Equipment ☐ Employer Group ☐ Extended Care Facility ☐ Government Agency/Public Health ☐ Home Health Agency ☐ Hospital/Health Care System ☐ Managed Care/HMO Provider ☐ Pharmacy ☐ Physician Office or Group ☐ Religious establishment ☐ Other

Are you adding additional program locations at this time? ☐ Yes ☐ No If "Yes" identify the site name(s) and location(s) below and mark the appropriate box to identify population targeted.	
Name: Address:	Comments:

Including any new sites, indicate the total number of locations where DSME/T services are provided, per setting type: (include any added as above and the current number of locations):

- ☐ Academic .... #
- ☐ Clinic .... #
- ☐ Community site .... #
- ☐ Extended care facility .... #
- ☐ Federally qualified health center .... #
- ☐ Health department .... #
- ☐ Hospital outpatient department .... #
- ☐ Library .... #
- ☐ Mobile van .... #
- ☐ Pharmacy .... #
- ☐ Physician office .... #
- ☐ Private home .... #
- ☐ Religious establishment .... #
- Other .... #

The sections below should be completed for each site. Please briefly describe any significant change in participant attendance numbers, or target population, including target population characteristics, and identify any plans to address:

Significant changes in participant attendance:	
Significant changes in target population:	
Plans to address these changes:	

TARGET POPULATION

Identify your target population according to the following:	Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Pediatrics ☐ Prediabetes ☐ Pump training ☐ Continuous glucose monitoring ☐ Other: Geographic Reach: ☐ Small - geographic area/local community ☐ Large – specifically defined geographic area ☐ Expansive geographic area Volume: ☐ 20 participants or less monthly ☐ 21-100 monthly ☐ 101-400 monthly ☐ 401 or greater monthly

PROGRAM STAFF

Name of Program Coordinator:	
Telephone:	
E-mail:	
Name of Instructor (1):	
Credentials:	BC-ADM ☐ CDE ☐ DO ☐ DPM ☐ MD ☐ NP/CNS ☐ PA ☐ PharmD ☐ RD ☐ RPh ☐ RN ☐ Other
Name of Instructor (2):	
Credentials:	BC-ADM ☐ CDE ☐ DO ☐ DPM ☐ MD ☐ NP/CNS ☐ PA ☐ PharmD ☐ RD ☐ RPh ☐ RN ☐ Other
Name of Instructor (3):	
Credentials:	BC-ADM ☐ CDE ☐ DO ☐ DPM ☐ MD ☐ NP/CNS ☐ PA ☐ PharmD ☐ RD ☐ RPh ☐ RN ☐ Other

Name of Community Health Worker (CHW)(1):	
Name and credentials of CHW supervisor:	
Training provided to CHW staff:	☐ Attended comprehensive DSME/T course ☐ Other

Name of Community Health Worker(2):	
Name and credentials of CHW supervisor:	
Training provided to CHW staff:	☐ Attended comprehensive DSME/T course ☐ Other

BEHAVIOR CHANGE GOAL ACHIEVEMENT

Select whether participants achieved behavior change goals according to target for each of the AADE7 behavior change categories:

Healthy eating	☐ Met/exceeded	☐ Not met
Being Active	☐ Met/exceeded	☐ Not met
Monitoring	☐ Met/exceeded	☐ Not met
Taking Medication	☐ Met/exceeded	☐ Not met
Problem Solving	☐ Met/exceeded	☐ Not met
Healthy Coping	☐ Met/exceeded	☐ Not met
Reducing Risks	☐ Met/exceeded	☐ Not met

Describe any plan/s to address target/s not met:

POST-INTERMEDIATE OR LONG TERM HEALTH "OUTCOME"

Identify which post-intermediate or long term health "outcome" was measured and describe why:

Post-intermediate:	Long term:
☐ A1C	☐ Quality of life
☐ BP	☐ Hospitalization
☐ BMI	☐ Productivity
☐ Lipids	☐ Other
☐ Dilated eye exam	
☐ Foot exam	
☐ Customer satisfaction	
☐ Other	
Why did you choose this measure?	Why did you choose this measure?

Describe how you analyzed the measure:

Describe, or submit a report that describes, one CQI/Performance Improvement project:

PAYMENT INFORMATION

Method of payment	
Credit Card:	Type: ☐ Amex ☐ Discover ☐ MasterCard ☐ Visa
	Card #:
	Exp. Date:
Check:	Check #:
Billing Address:	First Name:
	Last Name:
	Telephone:
	Street:
	City:
	State:
	Zip Code:
Type of Address:	Residence: ☐ Business: ☐
Make Checks Payable to American Association of Diabetes Educators (memo: DEAP) and mail to: AADE – Products 4411 Carol Stream, IL 60122-4414 *Please note this address is a lockbox. **Checks may only be sent via USPS. Other mail delivery services such as FedEx, UPS and DHL cannot be used.**	

NEXT STEPS:

SUPPORTING DOCUMENTS TO BE SUBMITTED:

- Resumes of program coordinator and instructors
- Proof of licenses and/or certification for all instructors
- Evidence of continuing education for all program staff

NOTE: If there is more than 1 location where DSMT services are provided, during the telephone interview, you will be required to discuss information related to ensuring that quality services are provided at each location and that educational services are tailored to meet needs, particularly if the needs of the targeted population vary among sites. **Additional materials for specific sites may be required to be submitted for review.**

NOTE: Reaccreditation application and supporting documents (component #2) are mailed to AADE Headquarters, address on next page.

SUBMISSION OF SUPPORTING DOCUMENTATION

Mail to:	American Association of Diabetes Educators Attn: DEAP 200 West Madison Street, Suite 800 Chicago, Illinois, 60606
Tel:	800-338-3633
E-mail to:	DEAP@aadenet.org
Fax to:	312.424.2427