

AADE APPLICATION FOR INITIAL ACCREDITATION (COMPONENT #1)

BY PROCEEDING WITH THIS APPLICATION I AFFIRM THE FOLLOWING:

1. I have read and understand the National Standards for Diabetes Self-Management Education Program (NSDSMEP) quality standards, accreditation program policies and procedures and the instructions for AADEs accreditation process and, if accredited, agree to comply with requirements for maintaining accreditation standards.
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 and comply with their requirements 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 DSME/T participants.

NAME OF PERSON COMPLETING APPLICATION:	
TITLE:	
DATE APPLICATION SUBMITTED:	

PROGRAM DEMOGRAPHICS

Program Mailing and Contact information:	
Name of Program:	
Street	
City:	
State:	
Zip Code:	
Telephone:	
Facsimile:	
<p>Geographic Reach:</p> <p><input type="checkbox"/> Small geographic area/local community</p> <p><input type="checkbox"/> Large - specifically defined geographic area</p> <p><input type="checkbox"/> Expansive geographic area</p> <p>Expected volume:</p> <p><input type="checkbox"/> 20 participants or less monthly</p> <p><input type="checkbox"/> 21-100 monthly</p> <p><input type="checkbox"/> 101 - 400 monthly</p> <p><input type="checkbox"/> 401 or greater monthly</p>	
<p>Setting/s in which the DSME/T program provides services</p> <p><input type="checkbox"/> Academic #</p> <p><input type="checkbox"/> Clinic #</p> <p><input type="checkbox"/> Community site #</p> <p><input type="checkbox"/> Extended care facility #</p> <p><input type="checkbox"/> Federally qualified health center #</p> <p><input type="checkbox"/> Health department #</p> <p><input type="checkbox"/> Hospital outpatient department #</p> <p><input type="checkbox"/> Library #</p> <p><input type="checkbox"/> Mobile van #</p> <p><input type="checkbox"/> Pharmacy #</p> <p><input type="checkbox"/> Physician office #</p> <p><input type="checkbox"/> Private home #</p> <p><input type="checkbox"/> Religious establishment #</p> <p>Other #</p>	

Indicate the address (and name if applicable) for each location where services are provided and mark the appropriate box to identify population targeted.

<p>Name (as applicable) and address for each additional site where this Program's DSME/T services are provided. Name: Address:</p>	<p>Population targeted:</p> <p><input type="checkbox"/> Type 1 diabetes</p> <p><input type="checkbox"/> Type 2 diabetes</p> <p><input type="checkbox"/> Gestational diabetes</p> <p><input type="checkbox"/> Pediatrics</p> <p><input type="checkbox"/> Prediabetes</p> <p><input type="checkbox"/> Pump training</p> <p><input type="checkbox"/> Continuous glucose monitoring</p> <p><input type="checkbox"/> Other:</p>
<p>If you have multiple locations where services are provided, select 1 location identified above and describe one characteristic of the target population that could be identified as "unique" and describe how you tailored program structure, process, or educational delivery:</p>	<p>Characteristic: Program tailored:</p>
<p>Name of Sponsoring/Affiliate Organization</p>	
<p>Address:</p>	
<p>City:</p>	
<p>State:</p>	
<p>Zip code:</p>	
<p>Name of Administrator:</p>	
<p>Title:</p>	

Sponsoring 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

PROGRAM STAFF

Name of Program Coordinator:	
Telephone:	
E-mail:	
Credentials:	
Proof of continuing education:	
Name of Instructor (1):	
Credentials:	BC-ADM <input type="checkbox"/> CDE <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> MD <input type="checkbox"/> NP/CNS <input type="checkbox"/> PA <input type="checkbox"/> PharmD <input type="checkbox"/> RD <input type="checkbox"/> RPh <input type="checkbox"/> RN <input type="checkbox"/> Other <input type="checkbox"/>
Name of Instructor (2):	
Credentials:	BC-ADM <input type="checkbox"/> CDE <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> MD <input type="checkbox"/> NP/CNS <input type="checkbox"/> PA <input type="checkbox"/> PharmD <input type="checkbox"/> RD <input type="checkbox"/> RPh <input type="checkbox"/> RN <input type="checkbox"/> Other <input type="checkbox"/>
Name of Instructor (3):	
Credentials:	BC-ADM <input type="checkbox"/> CDE <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> MD <input type="checkbox"/> NP/CNS <input type="checkbox"/>

	PA <input type="checkbox"/> PharmD <input type="checkbox"/> RD <input type="checkbox"/> RPh <input type="checkbox"/> RN <input type="checkbox"/> Other <input type="checkbox"/>
Name of Community Health Worker (CHW), if applicable (1):	
Name and credentials of supervisor:	
Training provided to CHW:	<input type="checkbox"/> Attended comprehensive DSME/T course <input type="checkbox"/> Other
Name of CHW (2):	
Name and credentials of supervisor:	
Training provided to CHW:	<input type="checkbox"/> Attended comprehensive DSME/T course <input type="checkbox"/> Other

SUPPORTING DOCUMENTS INCLUDE THE FOLLOWING:

- Program description, including mission, and organizational chart
- Job descriptions for each of the positions within the entity's organization
- Resumes of program coordinator and instructors
- Proof of licenses and/or certification, and continuing education for the program coordinator and all instructors.
- Performance measurement plan/continuous quality improvement process
- Copy of one de-identified participant chart
- Outline of curriculum or copy of one complete section from the written curriculum.
- Advisory group composition,
- Sample education materials (English and non-English as appropriate)

NOTE: If there is more than 1 location where DSME/T 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.**

All supporting documents/materials (see Policy 1) must be submitted within two weeks.

PAYMENT INFORMATION

Method of payment	
Credit Card:	Type: <input type="checkbox"/> Amex <input type="checkbox"/> Discover <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa
	Card #:
	Exp. Date:
Check:	Check #:
Billing Address:	First Name:
	Last Name:
	Telephone:
	Street:
	City:
	State:
	Zip Code:
Type of Address:	Residence: <input type="checkbox"/>
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.	Business: <input type="checkbox"/>

Application fees are for administrative purposes and are non-refundable

NEXT STEPS:

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

Thank you for completing component number one of the application process. Supporting documentation submission, which comprises component number two, must occur within two weeks of date of application form submission. Component number three, telephone interview, will be scheduled by AADE staff after all materials are reviewed.

**SUBMISSION OF INITIAL APPLICATION AND SUPPORTING
DOCUMENTATION
(COMPONENT #2):**

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