

TRAINING AND COMPETENCY EVALUATION PROGRAM (TCEP) APPLICATION FOR REAPPROVAL



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Guidelines for Completion

This form is to be used to comply with paragraphs (A), (B) and (C) of Rule 3701-18-05 of the Ohio Administrative Code (OAC) in applying for reapproval of a training and competency evaluation program (TCEP). Guidelines for completion of this form are attached. This application and all supporting documentation must be submitted, along with the \$300 non-refundable fee (no cash or personal checks accepted) made payable to "Treasurer, State of Ohio," and mailed to the following address: Ohio Department of Health, NATCEP Unit Coordinator, P.O. Box 15278, Columbus, OH 43215-0278 no later than the 60th day prior to the TCEP's expiration date. If over-nighting the application, supporting documentation and fee, please mail to the following address: Ohio Department of Health, NATCEP Unit Coordinator, 246 North High Street, 1st Floor, Columbus, OH 43215.

1. **General Information:** Information requested in this section identifies the facility, agency or organization applying for reapproval of a TCEP.
2. **Statistics:** This section is for reporting on your enrollment data for the time period of the report (from the date of the last completed application to the date for completion of this application). Be sure to indicate actual dates covered by the report (the dates may not coincide with the dates of the approval time because this report is submitted prior to the end of the approved time). Provide information on all trainees enrolled in your TCEP.
3. **Faculty:**
 - A. List all faculty members, which include the program coordinator (PC) and each primary instructor (PI) who currently teaches in your program. Provide all information requested.
 - B. Complete this section only if you are adding faculty or changing the PC on this application. Be sure to include licensure information and a copy of the train-the-trainer (TTT) certificate, as well as verification of teaching if the TTT certificate is more than 24 months old. Please be advised that only registered nurses (RNs) may be used in non-facility-based TCEPs.
4. **Physical Facilities:**
 - A. Describe classroom location(s). Include laboratory simulation and the number of trainees each room will hold.
 - B. This information is needed to determine if a facility is eligible to have an approved TCEP. Complete this page for each long-term care facility (LTCF) used as a clinical/classroom site. Attach clinical site agreement if not renewed since last approval.
5. **Verification of Rule Compliance:** The pertinent sections of the rules have been listed for your information and verification of compliance.

6. **Curriculum Information:** This information is requested to determine how you schedule your TCEP.
7. **Attestation:** When you sign this section, you are attesting that the TCEP is in compliance with all of the rules. Because the PC, by rule, is responsible for compliance with the rules, the PC must sign the form. The facility administrator may co-sign.
8. **Reminders:** The Director of Health may request any additional information necessary to assess compliance with the applicable criteria for program approval. The applicant shall provide any requested information within the time specified by the director.

Application Checklist of Items

To be included with Application for Reapproval of TCEP

- _____ APPLICATION FORM COMPLETED ENTIRELY; SEND ORIGINAL
- _____ PROGRAM COORDINATOR/PRIMARY INSTRUCTOR INFORMATION (IF ADDING NEW FACULTY)
 - A. TTT certificate with proof of validity, as applicable
 - B. Written agreement between PC and employing agency
 - C. Resume, verification of employment and any additional information as requested
- _____ CONTRACTS OR LETTERS OF AGREEMENT WITH OTHER LTCFs THAT WILL SERVE AS CLINICAL SITES AS APPLICABLE
- _____ NON-REFUNDABLE FEE, IN THE AMOUNT OF \$300, PAYABLE TO THE TREASURER, STATE OF OHIO.
- _____ READ ALL OF THE ASSURANCES
- _____ APPLICATION SIGNED AND DATED

Mail one completed, original set of all of the above materials with the fee to:

**Ohio Department of Health
NATCEP Unit Coordinator
1st Floor**

P. O. Box 15278
Columbus, Ohio 43215-0278

Application for Approval

1. General Information:

Program Approval Number (must use program approval number listed on current Certificate of Completion): _____

Program Name (must use program name listed on current Certificate of Completion): _____

Address: _____

City: _____, Ohio ZIP: _____ County: _____ Phone: _____ Fax: _____

Program Coordinator: _____ Telephone: _____ Cell Phone: _____

E-mail Address of PC: _____

This program is currently approved as: _____ Non-facility based (NFB) _____ Facility based (FB)

2. Statistical Data: Provide statistics on the period from the date of initial approval OR from the date of your last reapproval application, as applicable, until the date of this reapproval application.

Actual Dates Covered by this Report: _____
(These dates should reflect the date the last reapproval application was signed through the date this application is signed.)

Total Number of Complete TCEPs Held during Reporting Period (75 hours or more): _____

Number of Trainees Enrolled during Entire Reporting Period: _____

3. **A. Faculty:** List current faculty. Provide requested information below for the PC and each PI who teaches in your program, including part-time faculty or substitutes. (Note: Non-facility-based programs may use only RNs). You may copy this page as needed for additional PIs.

Please complete section 3B only if you are adding PIs or changing the PC on this reapproval.

	Current Faculty	RN	LPN	Date last coordinated/taught
PC Name				
PI Name				
PI Name				
PI Name				

3. **B. Faculty:**

COMPLETE ONLY IF YOU ARE ADDING NEW FACULTY

A. Program Coordinator (PC)	B. Primary Instructor (PI)
Name: _____	Name: _____
Ohio RN License # _____	Ohio RN License # _____
Expiration Date: _____	Ohio LPN License # _____ (LPN can only be PI in facility-based TCEP)
Phone: _____	Expiration Date: _____
E-mail address: _____	Phone: _____
1. Length of experience as an RN: _____	E-mail Address: _____
2. Length of experience in chronic care: _____	1. Length of experience as a licensed nurse: _____
3. Number of years teaching adults: _____	2. Length of experience in chronic care: _____
4. Length of experience in a long-term care facility as an RN: _____	

<p>_____</p> <p>Education: _____</p> <p>Current Employer: _____</p> <p>Please attach a resume listing long-term care employers, along with verification of employment. Attach a copy of official Ohio TTT certificate (must include ODH seal). If TTT certificate is more than 24 months old, send "Trainee Report" as validation of working as a PC or PI.</p> <p>Attach written agreement between the PC and program if non-facility based or if not employed by the facility-based program.</p> <p>Is the PC the director of nursing of the sponsoring facility? _____</p> <p>Does PC expect to also be considered as a PI? _____ If yes, it is unnecessary to complete the PI section (B)</p>	<p>3. Number of years teaching adults: _____</p> <p>4. Length of experience in a long-term care facility: _____</p> <p>Education: _____</p> <p>Current Employer: _____</p> <p>Please attach a resume listing employers of long-term and/or chronic care, along with verification of employment.</p> <p>Attach a copy of official Ohio TTT certificate (must include ODH seal). If TTT certificate is more than 24 months old, send "Trainee Report" as validation of working as a PC or PI.</p> <p>Must complete for each added PI. May copy if needed.</p>
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4. A. Physical Facilities -- CLASSROOM SITE:

Provide this page for each classroom site. (This sheet may be copied if needed)

<p>Classroom Site Name: _____</p> <p>Address: _____</p> <p>City: _____, Ohio ZIP Code: _____ County: _____</p> <p>Phone: _____ Room Capacity: _____</p> <p>Description of room(s) used for classroom instruction and laboratory simulation (including room capacity):</p>
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B. Physical Facilities -- CLINICAL/LONG-TERM CARE FACILITY (LTCF) SITE:

Provide this page for each clinical site. (This sheet may be copied if needed)

Clinical/LTCF Site Name: _____

Address: _____ City: _____, Ohio ZIP Code: _____

County: _____ Telephone: _____

Clinical Agreement Attached: _____ Yes _____ No Number of Beds: _____

Ohio Administrative Code (OAC) rule 3701-18-06 (C): The director or the director's designee shall not approve or reapprove a TCEP conducted by or in a long-term care facility which during the previous two years from submission of its application for approval or reapproval:	YES	NO	If yes, list date.
Had its license revoked pursuant to Chapter 3721 of the Revised Code [OAC rule 3701-18-06 (C) (1)];			
OAC rule 3701-18-06 (C) (2): For the purposes of this paragraph, a facility is considered to have been determined to be out of compliance with the specified requirements if any of the following occurred during the previous two years:	YES	NO	If yes, list date.
In the case of a long-term care facility certified as a skilled nursing facility under Title XVIII of the Social Security Act, it operated under a waiver of the Medicare nurse staffing requirements established under Title XVIII of the Social Security Act [OAC rule 3701-18-06 (C) (2) (a)];			
In the case of a long-term care facility certified as a nursing facility under Title XIX of the Social			

Security Act, it operated under a waiver of the Medicaid nurse staffing requirements established under Title XIX of the Social Security Act, if the waiver was granted on the basis of a demonstration that the facility was unable to provide the nursing care required under the Medicaid requirements for a period in excess of 48 hours per week [OAC rule 3701-18-06 (C) (2) (b)];			
The long-term care facility was subject to an extended or partial extended Medicare or Medicaid certification survey [OAC rule 3701-18-06 (C) (2) (c)];			
The long-term care facility's participation in the Medicare or Medicaid program was terminated [OAC rule 3701-18-06 (C) (2) (d)];			
A civil money penalty or fine of not less than \$5,000 was imposed upon the facility because of Medicare or Medicaid certification deficiencies [OAC rule 3701-18-06 (C) (2) (e)];			
A denial of payment for Medicare or Medicaid admissions was imposed upon the facility because of Medicare or Medicaid certification deficiencies [OAC rule 3701-18-06 (C) (2) (f)];			
A temporary manager or a special master was appointed for the facility because of Medicare or Medicaid certification deficiencies [OAC rule 3701-18-06 (C) (2) (g)]; or			
The facility was closed or its residents were transferred because of Medicare or Medicaid certification deficiencies [OAC rule 3701-18-06 (C) (2) (h)].			

5. Verification of Rule Compliance: The TCEP verifies that it will comply with all requirements of the law, rules and policies as follows:

- The physical facilities for classroom instruction and laboratory simulation shall provide adequate space to accommodate all trainees; shall be clean, safe and meet local and state building and fire code requirements; shall have adequate lighting and comfortable temperatures and shall be equipped adequately with audio-visual equipment, and other teaching aids and equipment needed for simulation of resident care. [OAC rule 3701-18-10 (A-D)]
- Records shall be maintained for two years in a secure and confidential manner that is accessible to authorized individuals. Records must include all information required by the applicable rules. [OAC rule 3701-18-11 (A) (1) and (B) (1-3)]
- Any changes in PC, PI, classroom or clinical site or curriculum content greater than five hours, will be reported to the NATCEP unit at least 10 business days prior to the planned implementation date for the proposed change. [OAC rule 3701-18-06.1 (B)]

- The TCEP must inform the NATCEP unit of the intent to discontinue training activities at least 45 days before discontinuing the approved TCEP. [OAC rule 3701-18-06.1 (C)]
- Reports of schedules for the approved TCEP and lists of trainees must be submitted according to requirements. [OAC rule 3701-18-06.1 (D) and (G)]
- The TCEP must allow the director or the director's designee to conduct an unannounced inspection of each approved program during the first year after the initial approval and at least once during each approval period thereafter. The TCEP must also allow the director or the director's designee access to staff, facilities, classes and records of the approved TCEP. [OAC rule 3701-18-03 (A) (1-3)]
- Certificates, as prescribed by the NATCEP unit, must be issued to all trainees upon successful completion of the approved TCEP. [OAC rule 3701-18-06.1 (H)]
- A written agreement shall be maintained with at least one LTCF to provide the clinical experience portions of the approved TCEP. The approved TCEP shall ensure that the LTCFs used by the program remain in compliance with the requirements of the Social Security Act. [OAC rule 3701-18-08 (B) (1-4)]
- No approved TCEP shall impose a charge on an individual who is employed by or has received an offer of employment from an LTCF for participation in the approved TCEP, including any charge for textbooks, required course materials or competency evaluation. [OAC rule 3701-18-08 (H)] The approved TCEP shall use only qualified personnel in the roles of PC and PI, and assure the PC maintains overall responsibility for the approved TCEP as required. [OAC rule 3701-18-09]
- The approved TCEP shall not exceed 30 hours of class with any combination of media and/or guest lecturers. [OAC rule 3701-18-09 (I) and 3701-18-09 (K) (2)]
- If used, interactive videodiscs will not relieve the approved TCEP of the responsibilities to conduct the approved TCEP according to the requirements. [OAC rule 3701-18-09 (K) (3)]
- TCEP must maintain, at minimum, a ratio of one PC or PI for every eight trainees during the clinical portion of the approved TCEP. Only qualified PCs or PIs will conduct any of the clinical supervision. [OAC rule 3701-18-09 (E) and (H)]
- All trainees must be clearly identified as trainees during any direct contact with residents while enrolled in the approved TCEP. [OAC rule 3701-18-08 (C)]
- All absences are to be made up within 60 calendar days from the date of absence. Absences from the first 16 hours of classroom instruction shall be made up hour-for-hour before the trainee provides any nursing or nursing-related services involving direct contact with residents. [OAC rule 3701-18-08 (D)]

- The approved TCEP shall not allow any trainee to cheat or behave in a manner that is disruptive to the operation of the approved TCEP. [OAC rule 3701-18-08 (E)]
- The approved TCEP shall establish and implement a method by which the trainee may evaluate the approved TCEP. [OAC rule 3701-18-08 (F)]
- Each approved TCEP shall provide and assist the trainee in completing the registration forms for the state-administered competency evaluation program. [OAC rule 3701-18-08 (G)]
- For successful completion of an approved TCEP, at minimum the following must be met: the trainee attended all classroom instruction and clinical experience or made up any missed portion in accordance with the approved TCEP's policy; if the program used oral or written examinations or quizzes to evaluate the trainee, the trainee correctly answered an average of at least 70 percent; and the PC or PI documented that the trainee successfully completed skills testing for each task on which the trainee was tested. [OAC rule 3701-18-13 (E) (1-3)]

6. Curriculum Information:

A. Curriculum Type (circle one): ODH PROCARE ALLIANCE UNICARE HCR PROGRAM IN-HOUSE

(Copy of complete curriculum may be required with reapproval application if different from last approval period)

B. Briefly describe below the overall schedule plan [OAC Rule 3701-18-05 (C) (8)] that you most frequently use for scheduling and implementing both the classroom instruction and clinical experience portions of the program (e.g., classroom, M - F, 8 - 4:30 p.m. x 10 days and clinicals, 7 – 3:30 p.m. x 2 days for a total of 12 days).

7. Attestation:

I hereby certify the TCEP for which this reapproval application is now being made will be conducted in compliance with all applicable federal and state statutes, rules and policies governing TCEPs. I further certify that all information submitted in this application is true and accurate. I am aware that misrepresentation on this application may result in denial of approval or revocation of existing approval.

Signature of Program Coordinator (Mandatory)

Date

Signature of Administrator (Optional)

Date