

INSTRUCTION / INFORMATION SHEET

QUALIFIED EMPLOYER FACILITY FOR LICENSED MEDICATION AIDES

*In order for your application to be processed,
ALL REQUIRED SUPPORTING DOCUMENTATION MUST BE SUBMITTED
with the application and required fee unless otherwise directed in the instructions.*

Before completing the application package, please read the following.

APPLICATION FOR QUALIFIED EMPLOYER FACILITY FOR LICENSED MEDICATION AIDES

Part I-III, Complete all applicable information requested.

QUALIFIED EMPLOYER FACILITY REQUIREMENTS FOR LICENSED MEDICATION AIDES

To be considered as a qualified facility for pilot program participation:

1. The applicant shall meet the following minimum requirements:
 - A. Be licensed in good standing as a skilled nursing facility by the Illinois Department of Public Health (IDPH);
 - B. Have an overall Five Star Quality Rating of 3, 4, or 5 at the time of application. (Ratings are derived from the most recent data available on the Centers for Medicare and Medicaid Services (CMMS) website);
 - C. Certify that the employment of a licensed medication aide will not replace or diminish the employment of a registered nurse or licensed practical nurse at the facility;
 - D. Certify that a registered nurse will be on duty and present in the facility to delegate and supervise the medication administration by a licensed medication aide at all times when the medication aide is administering medication;
 - E. Certify that, with the exception of licensed health care professionals, only licensed medication aides will be employed in the capacity of administering medication; and
 - F. Certify that they will provide information regarding patient safety, efficiency and errors as determined by the Division. Failure to submit any required reports may be grounds for discipline or sanction under the Nurse Practice Act, the Nursing Home Administrators Licensing & Disciplinary Act {225 ILCS 70}, or the Nursing Home Care Act {210 ILCS 45};
2. Applicant facilities must also provide:
 - A. A sample curriculum, course schedule, list of instructors and other educational materials or documents to demonstrate that the applicant will be able to competently provide a course of instruction for employees that fulfills the Medication Aide Curriculum set forth in Section 1300.660 of the Administrative Rules for the Nurse Practice Act.
 - B. Copies of the two most recent annual licensure and certification surveys completed by IDPH.

ADDITIONAL FACTORS THAT MAY BE USED IN SELECTING QUALIFIED FACILITIES TO PARTICIPATE IN THE MEDICATION AIDE PILOT PROGRAM

1. An IDPH finding that the skilled nursing facility has been free from type B violations or other deficiencies related to the administration of medications and skilled nursing care in its two most recent annual licensure and certification surveys;
2. Geographic location of a skilled nursing facility;
3. Number of beds for which a skilled nursing facility is licensed;
4. Number of years that a skilled nursing facility or residential care facility has been licensed;
5. Compliance and safety history of a skilled nursing facility as evidenced by the annual licensure and certification survey's submitted with the pilot program applications;
6. Whether a skilled nursing facility is owned by an individual or entity that owns or operates additional nursing homes; and
7. Any other factors determined appropriate by the Department.

FEE AND ASSISTANCE IN COMPLETING APPLICATION

The application fee is \$500. The fee payment must be in the form of a check or money order payable to the Department of Financial and Professional Regulation. ***THIS FEE IS NOT REFUNDABLE.***

The application, supporting documents and fee payment should be forwarded to:

Illinois Department of Financial and Professional Regulation
ATTN: Division of Profession Regulation
P.O. Box 7007
Springfield, Illinois 62791

If assistance is needed, please contact Jerry Miller at: 217/782-7524 or jerry.r.miller@illinois.gov.

APPLICATION SUBMISSION DEADLINE

Applications to be approved or selected as a qualified facility for the pilot program will be accepted from **January 1, 2016 through March 31, 2016.**

All deficiencies in the pilot program application must be resolved within the time frames set forth in the deficiency notice.

APPROVED MEDICATION AIDE PROGRAMS PROVIDED BY THE QUALIFIED EMPLOYER FACILITY MUST MEET THE FOLLOWING CURRICULUM REQUIREMENTS:

- a) Approved medication aide programs shall include 10 hours of laboratory instruction, 30 hours of RN-supervised clinical practice with progressive responsibility for patient medication assistance, and 60 hours of classroom-based medication aide certified education that contains the following minimum components:
1. Medication Fundamental - 20 hours
 2. Safety - 7 hours
 3. Communication and Documentation - 8 hours
 4. Medical Administration, including but not limited to, the administration of medications only via oral or topical routes under the direction of a registered professional nurse - 20 hours
 5. Ethical and Legal Considerations - 5 hours
- b) A qualified facility may choose to use the National Council of State Boards of Nursing (NCSBN) Medication Assistant-Certified (MA-C) model curriculum. However, if any provisions of NCSBN curriculum conflicts with the requirements above, the above requirements shall prevail.
- c) For the purpose of this section, supervision shall mean close physical proximity by an RN to the activities performed by the student.
- d) The program shall be administered or supervised by an Illinois licensed RN with a minimum of a baccalaureate degree in nursing and a minimum of two years clinical experience in a long term care facility.

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ilcs 65/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

APPLICATION FOR Qualified Employer Facility for Licensed Medication Aides

The following materials are required to be submitted for application as a Qualified Employer Facility for Licensed Medication Aides:

1. Application for Qualified Employer Facility for Licensed Medication Aides. Type or print with black ink only.
2. Fee – \$500. Make check or money order payable to the Department of Financial and Professional Regulation. **THE FEE IS NOT REFUNDABLE.**
3. Two copies of the most recent annual licensure and certification surveys completed by IDPH.
4. Copy of the Licensed Medication Aides Curriculum that will be provided by the facility.
5. Affidavit – AF-QEF Form.

PART I: Application Category Information

1. PROFESSION NAME Qualified Employer Facility for Medication Aide	2. PROFESSION CODE 275	3. LICENSURE METHOD Non-examination	4. FEE \$500
--	--------------------------------------	---	----------------------------

PART II: Applicant Identifying Information

1. NURSING HOME ADMINISTRATOR OR RESPONSABLE PERSON		2. LICENSE NUMBER (If Applicable)	
3. NAME OF FACILITY		4. LICENSE NUMBER	
5. GEOGRAPHIC LOCATION NUMBER (Refer to : www.illinoiscourts.gov/images/Appellate.jpg)	6. NUMBER OF BEDS IN FACILITY	7. NUMBER OF YEARS FACILITY HAS BEEN LICENSED	
8. TELEPHONE NUMBER WHERE YOU MAY BE REACHED Business: (_____) _____ - _____ Business Email: _____ (Area Code) Fax: (_____) _____ - _____ (Area Code)			
9. DOES THE OWNER OF THE FACILITY OWN OR OPERATE ADDITIONAL NURSING HOMES IN ILLINOIS? (If yes, provide names and addresses of facilities)			

PART III: Certifying Statement

Under penalties of perjury, I declare that I have examined the application and all supporting documents submitted by me in connection therewith, and to the best of my knowledge, they are true, correct, and complete.

Signature of Applicant

Date

I UNDERSTAND THAT FEES ARE NOT REFUNDABLE. My signature above authorizes the Department of Financial and Professional Regulation to reduce the amount of this check if the amount submitted is not correct. I understand this will be done only if the amount submitted is greater than the required fee hereunder, but in no event shall such reduction be made in an amount greater than \$50.

Additional application forms can be downloaded from the IDFP Web site at www.idfpr.com

IMPORTANT NOTICE: Completion of this form is necessary for consideration for licensure under 225 ILCS 25/1 et. seq. (Illinois Compiled Statutes). Disclosure of this information is VOLUNTARY. However, failure to comply may result in this form not being processed.

SUPPORTING DOCUMENT

AFFIDAVIT

AF-QEF

APPLICANT: Complete the applicant section of this form, then sign and date the affidavit portion of this form.

1. NAME OF NURSING HOME ADMINISTRATOR OR RESPONSIBLE PERSON

2. LICENSE NUMBER OF NURSING HOME ADMINISTRATOR (IF APPLICABLE)

3. NAME AND LICENSE NUMBER OF HEALTH CARE FACILITY

4. ADDRESS AND PHONE NUMBER OF HEALTH CARE FACILITY

AFFIDAVIT

Pursuant to the Illinois Nurse Practice Act {225 ILCS 65} and Administrative Code {1300.630} all applicants to be considered as a qualified employer facility for the licensed medication aide pilot program must certify to the following:

- The employment of a licensed medication aide will not replace or diminish the employment of a registered nurse or licensed practical nurse at the facility;
- A registered nurse will be on duty and present in the facility to delegate and supervise the medication administration by a licensed medication aide at all times when the medication aide is administering medication;
- With the exception of licensed health care professionals, only licensed medication aides will be employed in the capacity of administering medication; and
- The Qualified Employer Facility will provide information regarding patient safety, efficiency and errors as determined by the Division. Failure to submit any required reports may be grounds for discipline or sanctions under the Nurse Practice Act, the Nursing Home Administrators Licensing & Disciplinary Act or the Nursing Home Care Act.

Signature

Date