

General information:

Healthcare facilities seeking trauma designation and using the American College of Surgeons (ACS) survey process shall complete this application and submit it in its entirety to the Office of EMS/Trauma Systems Coordination (OEMS/TS).

* A copy of the ACS Pre-Review Questionnaire must be submitted to OEMS/TS no later than 30 days prior to the facility's ACS survey.

Timely and Sufficient Application:

Excerpts from Trauma Facility Designation Rule 157.125

(d) For a facility seeking **INITIAL designation**, a timely and sufficient application shall include:

- (1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office;
- (2) full payment of the designation fee enclosed with the submitted "Complete Application" form;
- (3) any subsequent documents submitted by the date requested by the office;
- (4) a trauma designation survey completed within one year of the date of the receipt of the application by the office; and
- (5) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office

(e) If a hospital seeking initial designation fails to meet the requirements in subsection (d)(1) - (5) of this section, the application shall be denied.

(f) For a facility seeking **RE-DESIGNATION**, a timely and sufficient application shall include:

- (1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office one year or greater from the designation expiration date;
- (2) full payment of the designation fee enclosed with the submitted "Complete Application" form;
- (3) any subsequent documents submitted by the date requested by the office; and
- (4) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office no less than 60 days prior to the designation expiration date.

(g) If a healthcare facility seeking re-designation fails to meet the requirements outlined in subsection (f)(1) - (4) of this section, the original designation will expire on its expiration date.

Technical Assistance: Whom do I call for information or guidance while completing the application?

Answer: For content or clarification of questions please call or email us at:

Elizabeth Stevenson – 512/834-6700 ext. 2346
elizabeth.stevenson@dshs.state.tx.us

For *Technical Assistance* call (512) 834-6700 or email DSHS.EMS-TRAUMA@dshs.state.tx.us.



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Application Submission Instructions: (for initial and re-designation)

1. Fill out the “*Complete Trauma Facility Designation Application.*” Answer all questions completely and enclose attachments as necessary. If a question does not apply to your facility, answer with “n/a” (*not applicable*). Narrative answers may be written in the “text boxes” OR attached as separate documents to the application.

2. **STEP A:** Submit the following documents:

- two (2) copies of the “*Complete Trauma Facility Designation Application.*”
- the application fee: *\$10.00 per licensed bed* *
 - * *\$4,000 minimum fee / \$5,000 maximum fee for Level I and II*
 - * *\$1,500 minimum fee / \$2,500 maximum fee for Level III*
- a current letter from the Regional Advisory Council (RAC) with which the facility is affiliated confirming facility participation in RAC activities.

STEP B: Additionally, submit:

- two (2) copies of the completed ACS Pre-Review Questionnaire 30 days prior to your scheduled ACS visit.

3. Submit the required documents to:

Cash Receipts Branch, MC 2003
 Texas Department of State Health Services
 Office of EMS/Trauma Systems Coordination
 P.O. Box 149347
 Austin, TX 78714-9347



TEXAS DEPARTMENT OF STATE HEALTH SERVICES

Cash Receipts Branch, MC2003
Office of EMS/Trauma Systems Coordination
PO Box 149347
Austin, TX 78714-9347
(512) 834-6700

Complete Trauma Facility Designation Application
For Hospitals using the American College of Surgeons Verification Process

STEP A:

Date: _____

Designation Level Applying for: [] Level I [] Level II [] Level III

Hospital Name: _____

Mailing Address: _____

City, State, Zip: _____

County: _____

Trauma Service Area (TSA):---Choose---

[] Initial Designation [] Re-Designation Expiration Date: _____

Contact Person: _____ Email: _____

Title/position: _____

Phone Number(s): () - or () -

Fax Number(s): () - or () -

Number of licensed beds: _____ DSHS License Number: _____

Amount enclosed: \$ _____

Make check payable to: "Texas Department of State Health Services"
(Fee for Level I/II): \$10.00 per licensed bed - minimum fee \$4,000 / maximum fee \$5,000
(Fee for Level III): \$10.00 per licensed bed - minimum fee \$1,500/ maximum fee \$2,500

Typed name of CEO or authorized person Title:
Phone: () - Email _____

Signature (of CEO or authorized person) Date

1. (This question applies to Level III applicants only): Indicate the full-time subspecialty services that are on-call to the emergency department: orthopaedics neurosurgery
2. Proposed date(s) for ACS survey (Month/Year): _____
3. Attach a current letter from the appropriate Regional Advisory Council stating that your facility is meeting RAC participation requirements.
4. In narrative format, describe (attach separate document if needed):
 - a) in detail the role of your facility in regional trauma system planning.

 - b) the trauma-specific educational programs provided for your physicians, nurses, staff and pre-hospital personnel.

 - c) the trauma orientation process and annual credentialing for nurses throughout the continuum of care.

5. Does your hospital have a designated helipad? Yes No*
* If "No" please attach a narrative describing location, access and protocols for establishing a landing zone.

6. Complete the emergency department nursing staff certifications:

Total number of staff	-- choose --
Percent with TNCC	-- choose -- %
Percent with PALS	-- choose --%
Percent with ENPC	-- choose --%
Percent with ACLS	-- choose --%
Percent with CEN	-- choose -- %

7. Complete the surgical/ trauma ICU nursing staff certifications:

Total number of staff	-- choose --
Percent with TNCC	-- choose -- %
Percent with PALS	-- choose --%
Percent with ENPC	-- choose --%
Percent with ACLS	-- choose --%
Percent with CCRN	-- choose -- %

8. What percent of patients entered in the trauma registry are complete within 45 days of discharge? _____

STEP B: Two (2) copies of the completed ACS Pre-Review Questionnaire must be submitted to our office no later than 30 days prior to your scheduled ACS visit.