NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, process or rule clarification, please contact:

- **Neonatal Designation Coordinators**

  Debbie Lightfoot, RN – (512) 834-6700 Ext. 2032
  Debra.Lightfoot@DSHS.texas.gov

  Danielle Vargas, R.N. – (737) 218-7069
  Danielle.Vargas@DSHS.texas.gov

- **Designation Program Manager**

  Elizabeth Stevenson, RN – (512) 834-6794
  Elizabeth.Stevenson@DSHS.texas.gov

- Submit the application packet to our office within 120 days of the facility's completed self-survey report and attestation.
- For further information regarding the application process, go to Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter J, §133.184 - Designation Process

TEXAS Health and Human Services

Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely.

2. Compile all required documents for the application packet: application, payment, self-survey report with attestation, Plan of Correction (POC), Perinatal Care Region (PCR) participation letter, and any subsequent documents requested by the office.

3. Submit payment[1] and Remittance Form to:

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

4. Electronically submit application packets to:

   DSHS.EMS-TRAUMA@dshs.state.tx.us

   Subject line: Neonatal Application Packet: [Facility Name and PCR/TSA]

   - If unable to submit electronically, send via:

     US Postal Service:
     Department of State Health Services
     Office of EMS/Trauma Systems, MC1876
     P. O. Box 149347
     Austin, TX 78714-9347

     Other services (i.e. UPS or FedEx), or hand-delivery:
     Department of State Health Services
     Office of EMS/Trauma Systems, MC1876
     8407 Wall Street
     Austin, TX 78754

[1] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

TEXAS Health and Human Services

Neonatal Facility Designation Application – Level I

Date: _____
Facility Name: _____
Street Address: _____
City, State, Zip: _____
County: _____

Mailing Address (if different): _____
City, State, Zip: _____

Perinatal Care Region (PCR/TSA): --Choose-- Facility Level: Level I

☐ Initial Designation
☐ Change of Ownership/Location (CHOW)
☐ Designation Level Change
☐ Re-Designation Expiration Date:_____

DSHS Current License Number: _____
Number of licensed beds (*based on current facility license*): _____
Texas Provider Identifier (TPI) Number: _____

Payment amount[2] sent to the Cash Receipts Branch: $ _____
Check #: _____
* Make checks payable to: *Texas Department of State Health Services*

Neonatal Program Manager: _____
Title: _____
Phone number(s): _____ or _____
Email: _____

Neonatal Medical Director: _____
Phone: _____
Email: _____

Name of Facility CEO/President: _____
Title: _____
Phone: _____
Email: _____

Signature of CEO/President: _____ Date:_____

[2] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

TEXAS Health and Human Services

Neonatal Statistical Data:

Reporting year: _____
(For report year, use the most recent 12-month period, NOT last calendar year)

Total number of Well Nursery beds: _____
Average daily census: _____
Total live births for reporting period: _____
Total live births <35 weeks not transferred: _____
Total neonates transferred out: _____
Total multiple births (twins, triplets, etc.): _____
Total neonatal deaths: _____

_____ _____
Signature of Neonatal Program Manager Date

_____ _____
Signature of Neonatal Medical Director Date

Remittance Form *Budget/Fund: ZZ101-160 355726*

Send this form with your payment to:

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

Division: HCQSS/EMS Budget #: ZZ101
Program: Neonatal Designation Fund #: 160

Application For: Neonatal Facility Designation

Date: _____

Facility Level: Level I

Facility Name: _____
Street Address: _____
City, State, Zip: _____
County: _____

Perinatal Care Region (PCR/TSA): --Choose--

Fee[3] Amount Enclosed: _____
Make checks payable to: *Texas Department of State Health Services*
Check #: _____

[3] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

Required Documents:

- ☐ Completed designation application.
- ☐ Copy of the Remittance Form to *Cash Receipts* with payment.
- ☐ PCR Letter of Participation.
- ☐ Completed neonatal self-survey report with appropriate requested documents.
- ☐ Completed attestation form.
- ☐ Plan of Correction if appropriate.
- ☐ Any subsequent documents requested by the office.