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?

(3) Question: Whom do I call for information or guidance while completing the application?

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

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

Patricia Ashton-Garcia, RN 512/284-8401
Patricia.ashton-garcia@dshs.state.tx.us

Michael Murray, RN 512/284-1724
Michael.murray@dshs.state.tx.us

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
   Attn: Trauma Designation Program
   P.O. Box 149347
   Austin, TX 78714-9347

TEXAS DEPARTMENT OF STATE HEALTH SERVICES

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: _____
Hospital Owner[1]: _____
Tax ID#: _____
Street Address: _____ City, State, Zip: _____
Mailing Address: _____ City, State, Zip: _____
County: _____ Trauma Service Area (TSA):---Choose---

☐ **Initial Designation** ☐ **Initial Designation (Change of Ownership)**

☐ **Re-Designation** **Expiration Date:**_____

DSHS Current License Number:_____ DSHS New License Number (CHOW only):_____

Number of licensed beds:_____

Amount enclosed[2]: $_____
Trauma Nurse Coordinator/Program Manager: _____
Title/position: _____
Phone Number(s): (___) ___ - ____ or (___) ___ - ____
Fax Number(s): (___) ___ - ____ or (___) ___ - ____
Email: _____

Typed Name of Trauma Medical Director: _____

Trauma Medical Director Email Address:_____

Typed Name of CEO or authorized person:

_____ Title: _____

Signature of CEO or authorized person: _____ Date: _____

Phone: (___) ___ - ____ CEO or authorized person Email: _____

[1] Entity legally responsible for the operation of the hospital, whether by lease or ownership.
2 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

(This question applies to Level III applicants only): Indicate the full-time subspecialty services that are on-call to the emergency department: ☐ orthopaedics ☐ neurosurgery

1. Proposed date(s) for ACS survey (Month/Year): _____

2. Attach a current letter from the appropriate Regional Advisory Council stating that your facility is meeting RAC participation requirements.

3. 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.

   _____

4. 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.

5. 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 -- %

6. 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.