



MATERNAL FACILITY DESIGNATION APPLICATION LEVELS II, III, AND IV

General Information

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

- **Perinatal Designation Coordinators**

Debbie Lightfoot, RN – (512) 231-5614
Debra.Lightfoot@DSHS.texas.gov

Alisha Wilkin, RN – (512) 834-6743
Alisha.Wilkin@DSHS.texas.gov

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

Vicki Gloria, R.N. – (737) 218-7079
Vicki.Gloria@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 K, §133.204 - Designation Process](#)



Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely.
2. Compile all required documents for the application packet: application, payment, Survey Report, Plan of Correction (POC), Perinatal Care Region (PCR) participation letter, and any subsequent documents requested by the office.
3. Submit payment¹ 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: Maternal 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

¹Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



Maternal Facility Designation Application – Level II, III, and IV

Date:

Facility Name:
Street Address:
City, State, Zip:
County:
Mailing Address (if different):
City, State, Zip:

License Number: _____ Number of licensed beds: _____
Texas Provider Identifier²: _____
National Provider Identifier³ Number: _____
Perinatal Care Region (PCR/TSA): _____

Fee⁴ sent to the Cash Receipts Branch with Remittance form:

Facility Level: Level II Level III Level IV

Initial Designation

Change of Ownership/Location (CHOW) Designation Level Change

Re-Designation Expiration Date: _____

Maternal Program Manager:
Title:
Phone Number(s): _____ or _____
Email: _____

Maternal Medical Director:
Phone Number: _____
Email: _____

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

Signature of CEO/President: _____ Date: _____

² The Texas Provider Identifier (TPI) is a 9-character identifier issued for filing claims of reimbursement.

³ The National Provider Identifier is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS) for administrative and financial transactions.

⁴ Application fee: Level II - \$1,500.00, Level III - \$2,000.00 and Level IV - \$2,500.00.



Maternal Statistical Data:

Reporting month/year (mm/yy): _____ to _____
(Use the most recent 12-month period, i.e. 04/17 to 04/18)

Total number of vaginal deliveries:
Total number of forceps deliveries:
Total number of vacuum deliveries:

Total number of TOLAC⁵ attempts:
Total number of VBAC⁶ deliveries:

Total number of C-section deliveries:

Total number of multiples:

Total number of postpartum hemorrhage cases:

Total number of perinatal ICU admissions:

Total number of maternal-related deaths:

Total number of maternal transfers in from external facilities:
Total number denied:

Total number of maternal transfers out to external facilities:
Total number denied:

Signature of Maternal Program Manager _____ Date _____

Signature of Maternal Medical Director _____ Date _____

⁵ Trial of Labor After Cesarean

⁶ Vaginal Birth After Cesarean



Budget/Fund: ZZ101-160 355726

Remittance Form

Send this form with your payment to:

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

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

Application For: Maternal Facility Designation

Date

Facility Level: Level II Level III Level IV

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

Perinatal Care Region (PCR/TSA):

Fee⁷ Amount Enclosed:

Make checks payable to: *Texas Department of State Health Services*

Check Number:

⁷Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



Required Documents:

- Completed designation application form.
- Copy of the Remittance Form sent to *Cash Receipts* with fee.
- PCR Letter of Participation.
- The maternal designation survey report, including patient case reviews.
- Plan of correction if appropriate.
- Any additional documents requested by the office.