

Trauma Facility Designation Application Level III or Level IV

INSTRUCTIONS AND HELPFUL INFORMATION

General information

1. Where to call for information or guidance while completing the application:

For technical difficulties or surveyor information, call or email:

- Tambra Rogers - (512) 834-6700 ext. 2343
- Tambra.Rogers@dshs.state.tx.us

For process or rule clarification, the trauma designation coordinators are:

- Michael Murray, RN – (512) 284-1724
- Michael.Murray@dshs.state.tx.us
- Assigned Trauma Service Areas (TSA): A – B – D – F – G – H – I – J – K – Q – R

- Patricia Ashton-Garcia, RN – (512) 484-8401
- Patricia.Ashton-Garcia@dshs.state.tx.us
- Assigned Trauma Service Areas (TSA): C – E – L – M – N – O – P – S – T – U – V

- Patricia (Trish) Brachel, RN – (512) 834-6604
- Patricia.Brachel@dshs.state.tx.us

Manager, EMS/Trauma Systems Group

- Elizabeth Stevenson, RN – (512) 834-6794
- Elizabeth.Stevenson@dshs.state.tx.us

For RAC and Funding questions, call or email:

- Indra Hernandez – (512) 384-6669
- Indra.hernandez@dshs.state.tx.us

2. When should the application be submitted? Title 25 Texas Administrative Code (TAC) §157.125 provides the guidelines for submission of designation applications. According to TAC¹, a timely application is received in our office no later than one year prior to designation expiration.

¹ 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;

3. What else must be submitted to complete the designation process (after the survey)?
Two copies of the trauma designation survey report, including patient care reviews, and a Plan of Correction for deficiencies. The Letter of Participation from the Regional Advisory Council (RAC) must not be more than 180 days old. If a Letter of Participation was submitted with the timely application, a new RAC letter may be necessary. (Applicants recognized as “In Active Pursuit” status will need to send a second RAC letter if utilizing the full two years.)
4. Need more information relating to the designation process? Call your assigned Designation Coordinator (above) or refer to the “**Process for Trauma Facility Designation Application**” at the following Office of EMS/TS website:
www.dshs.state.tx.us/emstraumasystems/formsresources.shtm#trauma

(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.

Application Submission Instructions

1. Fill out the **Application**. Answer all questions completely and attach additional documents.

2. Submit payment² along with the **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

3. Submit application to: DSHS.EMS-TRAUMA@dshs.state.tx.us

Subject line: Trauma Application: [Facility Name and TSA]

4. Within 180 days of completion of the trauma designation survey performed by an office approved agency, mail (**no electronic versions allowed at this time unless specifically required**) submit the following documents to the Office of EMS/TS:

- Two copies of the trauma designation survey report, including patient care reviews, and a plan of correction for deficiencies.
- A current letter of participation from the RAC for the facility, must not be more than 180 days old.

Note: Initial applicants may need to send a second RAC letter if utilizing the full 2 years allowed for "In Active Pursuit" status.

For US Postal Service, use this address:

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

For other services (i.e. UPS or FedEx), or to hand-deliver, use this address :

Department of State Health Services
Office of EMS/Trauma Systems, MC1876
8407 Wall Street
Austin, TX 78754

² Application fee: Level III - \$10.00 per licensed bed; \$1,500 minimum/\$2,500 maximum.
Level IV - \$10.00 per licensed bed; \$500 minimum/\$1,000 maximum.

Trauma Facility Designation Application Level III or Level IV

Date:

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

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

Trauma Service Area (TSA):

Facility Level: Level III Level IV

Initial Designation

Change of Ownership/Location (CHOW)

Designation Level Change

Re-Designation

Expiration Date:

Number of licensed beds (*based on current facility license*):

Payment amount³ sent to the Cash Receipts Branch: \$

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

Trauma Program Manager:

Title:

Phone Number(s):

or

Email:

Trauma Medical

Director: Phone Number:

Email:

Name of Facility CEO/President:

Title:

Phone:

Email:

Signature of CEO/President:

Date:

³ Application fee: Level III - \$10.00 per licensed bed; \$1,500 minimum/\$2,500 maximum.
Level IV - \$10.00 per licensed bed; \$500 minimum/\$1,000 maximum.

Attachments

- The current resolution supporting the trauma center signed by the facility's governing body. (Not older than 12 months.)
- The current resolution supporting the trauma program and designation signed by the facility's medical staff. (Not older than 12 months.)
- The Trauma Team Activation Policy, including the Roles and Responsibilities of the Trauma Team.
- The trauma Triage, Transfer, and Admission criteria policy.

Statistical Data

- Reporting year: _____ to _____
(Choose the most recent year with complete data, i.e. 4/2014 to 4/2015)
- Total number of Emergency Department (ED) visits for reporting year:
(Include Dead on Arrival (DOA) and Died in ED (DIE).)
- Total number of trauma-related ED visits:

Trauma Service	Number of Admissions
Orthopedic Service	
Neurosurgical Service	
Other Surgical Service	
Non-Surgical Service	
Deaths	
Total	

- Number of trauma related penetrating injuries, burns, blunt trauma, and other.

Penetrating injuries	
Burns	
Blunt	
Other (drowning, etc.)	

- Trauma-related disposition from ED:

ED to Operating Room	
ED to Intensive Care Unit	
ED to Floor	
ED to another facility (Transfer)	

Deaths	
Total	

Signature of Trauma Program Manager

Signature of Trauma Medical Director

Date

Date

Remittance Form

Budget/Fund: ZZ100-160 356002

Remittance Form

Send this form with the 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 #: ZZ100
Program: Trauma Fund #: 160

Application For: Trauma Facility Designation

Date:

Facility Level: Level III Level IV

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

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

Fee⁴ Amount Enclosed:

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

⁴ Application fee: Level III - \$10.00 per licensed bed; \$1,500 minimum/\$2,500 maximum.
Level IV - \$10.00 per licensed bed; \$500 minimum/\$1,000 maximum.

Designation Process Checklist

Attachments to the Application:

- Copy of the Remittance Form to “Cash Receipts”
- Facility’s Governing Body Resolution
- Medical Staff Resolution
- Trauma Team Activation Policy, including Roles and Responsibilities
- Trauma Triage, Transfer, and Admission criteria policy
- The RAC Letter of Participation (must not be more than 180 days old).

After the designation survey:

- Two copies of the trauma designation survey report, including patient care reviews.
- Plan of correction for potential deficiencies.
- Applicants recognized as “In Active Pursuit” status will need to send a second RAC letter if utilizing the full two years.