## General information:

1) Healthcare facilities seeking STROKE designation and using The Joint Commission (TJC), Det Norske Veritas (DNV), or the Healthcare Facilities Accreditation Program (HFAP) certification process shall complete this application and submit it in its entirety to the Office of EMS/Trauma Systems Coordination (OEMS/TS).

## Timely and Sufficient Application:

Excerpts from Stroke Facility Designation Rule 157.133

*(f) A timely and sufficient application for a facility seeking initial designation shall include:*
- *(1) the department's current "Complete Application" for the requested level of stroke facility designation, 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 non-refundable $100 designation fee enclosed with the submitted "Complete Application" form;*
- *(3) any subsequent documents submitted by the date requested by the office;*
- *(4) a stroke 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.*

*(g) If a healthcare facility seeking initial designation fails to meet the requirements in subsection (f)(1) - (5) of this section, the application shall be denied.*

*(h) A timely and sufficient application for a stroke facility seeking re-designation shall include:*
- *(1) the department's current "Complete Application" form for the requested level of stroke facility designation, 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 before the designation expiration date;*
- *(2) full payment of the non-refundable $100 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.*

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

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

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

Patricia Ashton-Garcia – 512/484-8401
Patricia.ashton-garcia@dshs.state.tx.us

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

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

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

1. Fill out the "*Complete Stroke 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. Submit the following documents:

   - two (2) copies of the "*Complete Stroke Facility Designation Application"*
   - the application fee: *$100.00*
   - a current letter from the Regional Advisory Council (RAC) with which the facility is affiliated confirming facility participation in RAC activities
   - two (2) copies of the letter of certification as a stroke center from The Joint Commission or DNV, or HFAP
   - the entire survey report
   - if applicable, any corrective action plan required by The Joint Commission or DNV, or HFAP

3. Submit the required documents to:

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

# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

**Office of EMS/Trauma Systems Coordination**
**P. O. Box 149347**
**Austin, TX 78714-9347**
**(512) 834-6700**

## Complete Stroke Facility Designation Application

Date: _____

☐ **Comprehensive Stroke Center (Level I)** ☐ **Primary Stroke Center (Level II)**

Hospital Name: _____ Tax ID#: _____
Hospital Owner[1]: _____
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 (based on most recent licensing survey): _____

Amount enclosed: $_____ Make check payable to: "*Texas Department of State Health Services*"

Stroke Nurse Coordinator/Program Manager: _____

Title/position: _____

Email: _____

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

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

Typed name of Stroke Medical Director: _____

Signature of Stroke Medical Director: _____ Date: _____
Stroke Medical Director Email: _____

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.

1. List the names and contact info for the nurse program manager and the physician director for the stroke program.

   Nurse Manager: _____

   Title/position: _____

   Email: _____

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

   Physician Director: _____

   Title/position: _____

   Email: _____

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

2. Date of The Joint Commission, DNV, or HFAP survey: _____

3. Current stroke certification expiration with The Joint Commission, DNV, or HFAP: _____