Stroke Facility Designation Application
Level I or Level II

Date:

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

Trauma Service Area (TSA):
License Number: Number of licensed beds:

Facility Level: Level I ☐ Level II ☐

☐ **Initial Designation**
☐ Change of Ownership/Location (CHOW) ☐ Designation Level Change

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

Stroke Certification Agency: **TJC** ☐**DNV-GL** ☐**HFAP** ☐**CIHQ** ☐

Certification Expiration Date:

Stroke Program Manager:
Phone Number(s): or
Email:

Stroke Medical Director:
Phone Number:
Email:

Chief Nursing Officer:
Phone Number(s): or
Email:

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

Signature of CEO/President: ______________________________
Date Signed:

Facility Name: TSA:

Statistical Data:

- Reporting year: to
  Choose the most recent year with complete data, i.e. 1/2017 to 1/2018.

- Total Emergency Department (ED) visits for reporting year:
  Include Dead on Arrival (DOA) and Died in ED (DIE)

- Total number of stroke-related ED visits:

- Number of stroke related admissions:

ED to Intensive Care Unit	
ED to Floor	
Deaths	
Total	

- Number of stroke related transfers:

Transfer In - Air	
Transfer In - Ground	
Transfer Out - Air	
Transfer Out - Ground	

- Nursing staff education:

	Percent of All ED Nurses	**Percent of Registered Nurses**
ACLS		
NIHH		
Dysphasia Screening		
Thrombolytic Therapy		

Signature of Stroke Program Manager Date

Signature of Stroke Medical Director Date

Budget/Fund: ZZ100-160 356002

Remittance Form

Send this form with your fee to:

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

Division: HCQSS/EMS Budget #: ZZ100 Program: Stroke Fund #: 160

Application For: Trauma Facility Designation

Date:

Facility Level: Level I ☐ Level II ☐

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

Trauma Service Area (TSA):

Fee Amount Enclosed: Check Number:

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

Designation Process Checklist

Attachments to the Application:

- ☐ Copy of the Remittance Form sent to "Cash Receipts"
- ☐ The RAC Letter of Participation (must not be more than 180 days old).

After the verification review:

- ☐ The complete verification report, including reporting requirements
- ☐ The complete survey report, including patient care reviews
- ☐ An updated RAC letter if the original letter is greater than 12 months old.