Trauma Facility Designation Application

Date: _____

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

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

Fee[1] sent to the Cash Receipts Branch with Remittance Form: _____

Facility Level: Level I ☐ Level II ☐ Level III ☐ Level IV ☐

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

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

Trauma Program Manager: _____
Phone Number(s): _____ or _____
Email: _____

Trauma Medical Director: _____
Phone Number: _____
Email: _____

President/CEO: _____
Title: _____
Phone: _____
Email: _____

Signature of President/CEO: _____
Date Signed: _____

[1] Application fee:
- Level I: $10.00 per licensed bed; $4,000 minimum/$5,000 maximum.
- Level II: $10.00 per licensed bed; $4,000 minimum/$5,000 maximum.
- 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.

Facility Name: _____ **TSA:** _____

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

Attachments:

- The current resolution supporting the trauma center signed by the facility's governing body. (No older than 12 months.)
- The current resolution supporting the trauma program and designation signed by the facility's medical staff. (No older than 12 months.)

Statistical Data:

1. Reporting year: _____ to _____
   C*hoose the most recent 12 months with complete data, i.e. 1/2017 to 1/2018.*

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

3. Total number of trauma-related ED visits: _____

4. Number of trauma related admissions:

Trauma Service	
Orthopedic Service	
Neurosurgical Service	
Other Surgical Service	
Non-Surgical Service	
Total	0

5. Number of trauma related injuries:

Penetrating injuries	
Burns	
Blunt Trauma	
Other (drowning, etc.)	
Total	0

Facility Name: _____ **TSA:** _____

6. Trauma-related disposition from ED:

ED to Operating Room	
ED to Intensive Care Unit	
ED to Floor	
ED to another facility (Transfer)	
Deaths	
Total	0

_____ _____
Signature of Trauma Program Manager Date

_____ _____
Signature of Trauma 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: Trauma Fund #: 160

Application For: Trauma Facility Designation

Date:_____

Facility Level: Level I ☐ Level II ☐ Level III ☐ Level IV ☐

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

Trauma Service Area (TSA):_____

Fee[2] Amount Enclosed: _____ Check Number: _____
Make checks payable to: *Texas Department of State Health Services*

[2] Application fee:
- Level I: $10.00 per licensed bed; $4,000 minimum/$5,000 maximum.
- Level II: $10.00 per licensed bed; $4,000 minimum/$5,000 maximum.
- 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"
- ☐ Governing Body Resolution
- ☐ Medical Staff Resolution
- ☐ The RAC Letter of Participation (must not be more than 180 days old).

After the designation survey:

- ☐ Trauma designation survey report, including patient care reviews.
- ☐ Plan of correction for all potental deficiences.
- ☐ An updated RAC letter if the original letter is greater than 12 months old.