



MATERNAL FACILITY DESIGNATION APPLICATION LEVEL I

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
 - Danielle Vargas, R.N. – (737) 218-7069
Danielle.Vargas@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, Self 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 I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



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 _____

⁵Trial of Labor After Cesarean

⁶Vaginal Birth After Cesarean

Revised September 13, 2018



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 I

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 I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



Required Documents:

Completed designation application form.

Copy of the Remittance Form sent to *Cash Receipts* with payment.

PCR Letter of Participation.

Completed maternal self survey report with appropriate requested documents.

Completed attestation form.

Plan of correction if appropriate.

Any subsequent documents requested by the office.