



NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, process or rule clarification, please contact:

- **Neonatal Designation Coordinators**

Debbie Lightfoot, RN – (512) 834-6700 Ext. 2032

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Alisha Wilkin, RN – (512) 834-6743

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Vicki Gloria, R.N. – (737) 218-7079

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- **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 J, §133.184 - 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 with attestation, 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: Neonatal 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

¹ Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



Neonatal Facility Designation Application – Level I

Date:

Facility Name:

Street Address:

City, State, Zip:

County:

Mailing Address (if different):

City, State, Zip:

Perinatal Care Region (PCR/TSA):

Facility Level: Level I

Initial Designation

Change of Ownership/Location (CHOW)

Designation Level Change

Re-Designation

Expiration Date:

DSHS Current License Number:

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

Texas Provider Identifier (TPI) Number:

Payment amount² sent to the Cash Receipts Branch: \$

Check #:

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

Neonatal Program Manager:

Title:

Phone number(s):

or

Email:

Neonatal Medical Director:

Phone:

Email:

Name of Facility CEO/President:

Title:

Phone:

Email:

Signature of CEO/President:

Date:

² Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



Neonatal Statistical Data:

Reporting year:

(For report year, use the most recent 12-month period, NOT last calendar year)

Total number of Well Nursery beds:

Average daily census:

Total live births for reporting period:

Total live births <35 weeks not transferred:

Total neonates transferred out:

Total multiple births (twins, triplets, etc.):

Total neonatal deaths:

Signature of Neonatal Program Manager

Date

Signature of Neonatal Medical Director

Date



Remittance Form

Budget/Fund: ZZ101-160 355726

Send this form with your 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 #: ZZ101
Program: Neonatal Designation Fund #: 160

Application For: Neonatal Facility Designation

Date:

Facility Level: Level I

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

Perinatal Care Region (PCR/TSA): _____

Fee³ Amount Enclosed:

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

Check #:

³ Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



Required Documents:

- Completed designation application.
- Copy of the Remittance Form to *Cash Receipts* with payment.
- PCR Letter of Participation.
- Completed neonatal self-survey report with appropriate requested documents.
- Completed attestation form.
- Plan of Correction if appropriate.
- Any subsequent documents requested by the office.