

# Neonatal Facility Designation Application Level I

## INSTRUCTIONS AND HELPFUL INFORMATION

### General Information

1. Where to call for information or guidance while completing the application:

For technical assistance, call or email the Neonatal Program Specialist:

- Jewell Potter - (512) 834-6743
- [Jewell.Potter@dshs.state.tx.us](mailto:Jewell.Potter@dshs.state.tx.us)

For process or rule clarification, please contact the following:

Neonatal Designation Coordinator

- Debbie Lightfoot, RN – (512) 834-6700 Ext. 2032
- [Debra.Lightfoot@dshs.state.tx.us](mailto:Debra.Lightfoot@dshs.state.tx.us)

Designation Program Manager

- Elizabeth Stevenson, RN – (512) 834-6794
- [Elizabeth.Stevenson@dshs.state.tx.us](mailto:Elizabeth.Stevenson@dshs.state.tx.us)

2. When should the application be submitted? Title 25 Texas Administrative Code (TAC) §133 Subchapter J, provides the guidelines for submission of designation application packets. According to TAC<sup>1</sup>, a designation application packet shall be submitted to our office within 120 days of the facilities completed self-audit and attestation.
3. Need more information relating to the designation process? Call your assigned Designation Coordinator (above) or refer to the “Process for Neonatal Facility Designation Application” at the following Office of EMS/TS website:  
[www.dshs.state.tx.us/emstraumasystems/neonatal.aspx](http://www.dshs.state.tx.us/emstraumasystems/neonatal.aspx)

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TAC<sup>1</sup> §133.184. Designation Process.

(a) Designation application packet. The applicant shall submit the packet, inclusive of the following documents to the Office of EMS/Trauma Systems Coordination (office) within 120 days of the facility's survey date:

- (1) an accurate and complete designation application form for the appropriate level of designation, including full payment of the designation fee as listed in subsection (d) of this section;
  - (2) any subsequent documents submitted by the date requested by the office;
  - (3) a completed neonatal attestation and self-survey report for Level I applicants or a designation survey report, including patient care reviews if required by the office, for Level II, III and IV applicants;
  - (4) a plan of correction (POC), detailing how the facility will correct any deficiencies cited in the survey report, to include: the corrective action; the title of the person responsible for ensuring the correction(s) is implemented; how the corrective action will be monitored; and the date by which the POC will be completed; and
  - (5) evidence of participation in the applicable Perinatal Care Region (PCR).
- (b) Renewal of designation. The applicant shall submit the documents described in subsection (a)(1) - (5) of this section to the office not more than 180 days prior to the designation expiration date and at least 60 days prior to the designation expiration date.

## Application Submission Instructions:

1. Fill out the **Application**. Answer all questions completely.
2. Compile all required documents for the application packet: application form, payment, self-audit with attestation, Plan of Correction (POC), Perinatal Care Region (PCR) participation letter, and any subsequent documents requested by the office.
3. Submit payment<sup>2</sup> along with the **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. Submit application packet to: [DSHS.EMS-TRAUMA@dshs.state.tx.us](mailto:DSHS.EMS-TRAUMA@dshs.state.tx.us)  
**Subject line:** Neonatal Application Packet: [Facility Name and PCR/TSA]

**For US Postal Service, use this address:**

Department of State Health Services  
Office of EMS/Trauma Systems, MC1876  
P. O. Box 149347  
Austin, TX 78714-9347

**For other services (i.e. UPS or FedEx), or to hand-deliver, use this address:**

Department of State Health Services  
Office of EMS/Trauma Systems, MC1876  
8407 Wall Street  
Austin, TX 78754

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<sup>2</sup> 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*):  
Tax ID Number:

Payment amount<sup>3</sup> sent to the Cash Receipts Branch: \$

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

Neonatal Program Manager:  
Title:  
Phone Number(s):                      or  
Email:

Neonatal Medical Director:  
Phone Number:  
Email:

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

Signature of CEO/President:

Date:

<sup>3</sup> 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)*

Total live births annually:

Total live births <35 weeks not transferred:

Total neonates transferred out:

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

Signature of Neonatal Program Manager

Signature of Neonatal Medical Director

Date

Date

*Remittance Form*

*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 Coordination  
P.O. Box 149347  
Austin, Texas 78714-9347**

Division: HCQSS/EMS  
Program: Neonatal Designation

Budget #: ZZ101  
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):

Fee<sup>4</sup> Amount Enclosed:

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

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<sup>4</sup> Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.

## **Designation Application Packet Checklist**

### **Required Documents:**

- Completed designation application form for the appropriate level of designation.
- Copy of the Remittance Form to “Cash Receipts” with payment.
- PCR Letter of Participation
- Completed neonatal self-audit form.
- Completed attestation form.
- Plan of correction if appropriate.
- Any subsequent documents requested by the office.