



NEONATAL FACILITY DESIGNATION APPLICATION LEVELS II, III, AND IV

General Information

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

- **Neonatal Designation Coordinators**

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

¹Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



Neonatal Facility Designation Application – Level II, III, and IV

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

Mailing Address (if different):
City, State, Zip:

Perinatal Care Region (PCR/TSA): _____

Facility Level: Level II Level III Level IV

Initial Designation
 Change of Ownership/Location (CHOW)
 Designation Level Change
 Re-Designation Expiration Date:

DSHS Current License Number:
Number of licensed beds (*from 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 II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



Neonatal Statistical Data:

Reporting year:

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

Level II (Special Care Nursery)

Total number of Well Nursery beds:

Total number of:	Beds	/	Census
• Special Care Nursery beds and Average daily census of SCN beds:		/	

Total live births for reporting period:

Total live births ≤ 32 weeks and birth weight ≤ 1500 grams:

Total neonates on assisted endotracheal ventilation > 24 hours or NCPAP until condition improved:

Total neonates/infants transferred in:

Total neonates/infants transferred out:

Total multiple births:

Total neonatal deaths:

Level III (Neonatal Intensive Care Unit) or Level IV (Advanced Neonatal ICU)

Total number of Well Nursery beds:

Total number of:	Beds	/	Census
• Special Care Nursery beds and Average daily census of SCN beds:		/	
• NICU beds and Average daily census of NICU beds:		/	
• Advanced NICU beds and Average daily census of Advanced NICU beds:		/	

Total live births for reporting period:

Total neonates/infants transferred in:

Total neonates/infants transferred out:

Total multiple births:

Total number of NICU patient surgical events:

Total OR number:

Total bedside number:

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 II Level III Level IV

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 #:

³Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



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.
- One copy of the neonatal designation survey report, including patient case reviews.
- Plan of correction if appropriate.
- Any subsequent documents requested by the office.