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

  Alisha Wilkin, RN – (512) 834-6743
  Alisha.Wilkin@DSHS.texas.gov

  Danielle Vargas, R.N. – (737) 218-7069
  Danielle.Vargas@DSHS.texas.gov

  Vicki Gloria, R.N. – (737) 218-7079
  Vicki.Gloria@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

TEXAS Health and Human Services

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 payment[1] 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 II - $1,500.00, Level III - $2,000.000 and Level IV - $2,500.00.*

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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): --Choose--

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 amount[2] 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.*

TEXAS Health and Human Services

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): --Choose--

Fee[3] Amount Enclosed: _____
Make checks payable to: *Texas Department of State Health Services*
Check #: _____

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

TEXAS Health and Human Services

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.