Stroke Facility Designation Application
Level I or Level II

Date: _____

Facility Name: _____
Street Address: _____
City, State, Zip: _____
County: _____
Mailing Address (if different): _____
City, State, Zip: _____

Trauma Service Area (TSA): _____
License Number: _____ Number of licensed beds: _____

Facility Level: Level I ☐ Level II ☐

☐ **Initial Designation**
☐ Change of Ownership/Location (CHOW) ☐ Designation Level Change

☐ **Re-Designation** **Expiration Date of Designation:** _____

Stroke Certification Agency: **TJC** ☐ **DNV-GL** ☐ **HFAP** ☐ **CIHQ** ☐

Certification Expiration Date: _____

Stroke Program Manager: _____
Phone Number(s): _____ or _____
Email: _____

Stroke Medical Director: _____
Phone Number: _____
Email: _____

Chief Nursing Officer: _____
Phone Number(s): _____ or _____
Email: _____

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

Signature of CEO/President: _____
Date Signed: _____

Facility Name: _____ TSA: _____

Statistical Data:

- Reporting year: _____ to _____
  Choose the most recent year with complete data, i.e. 1/2017 to 1/2018.

- Total Emergency Department (ED) visits for reporting year: _____
  Include Dead on Arrival (DOA) and Died in ED (DIE)

- Total number of stroke-related ED visits: _____

- Number of stroke related admissions:

ED to Intensive Care Unit	
ED to Floor	
Deaths	
Total	0

- Number of stroke related transfers:

Transfer In - Air	
Transfer In - Ground	
Transfer Out - Air	
Transfer Out - Ground	

- Nursing staff education:

	Percent of All ED Nurses	**Percent of Registered Nurses**
ACLS		
NIHSS		
Dysphagia Screening		
Thrombolytic Therapy		

_____ _____
Signature of Stroke Program Manager Date

_____ _____
Signature of Stroke Medical Director Date

Budget/Fund: ZZ100-160 356002

Remittance Form

Send this form with your fee to:

Texas Department of State Health Services
Cash Receipts Branch, MC 2003
Office of EMS/Trauma System
P.O. Box 149347
Austin, Texas 78714-9347

Division: HCQSS/EMS Budget #: ZZ100 Program: Stroke Fund #: 160

Application For: Stroke Facility Designation

Date: _____

Facility Level: Level I ☐ Level II ☐

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

Trauma Service Area (TSA): _____

Fee Amount Enclosed: $ 100.00 Check Number: _____

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

Designation Process Checklist

Attachments to the Application:

- ☐ Copy of the Remittance Form sent to “Cash Receipts”
- ☐ The RAC Letter of Participation (must not be more than 180 days old).

After the verification review:

- ☐ The complete verification report, including reporting requirements
- ☐ The complete survey report, including patient care reviews
- ☐ An updated RAC letter if the original letter is greater than 12 months old.