

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	

- 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		
NIHH		
Dysphasia 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: 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.