TEXAS Health and Human Services | Texas Department of State Health Services

TRAUMA FACILITY DESIGNATION APPLICATION

For general department or designation questions, contact a Designation Program Specialist:

Rebecca Dimas
(512) 657-0804
rebecca.wright@dshs.texas.gov

For designation process or rule clarification, contact a Trauma Designation Coordinator:

Audrey Green, RN
(512) 605-9108
audrey.green@dshs.texas.gov

Katie Foarde, RN
(737) 354-1849
katie.foarde@dshs.texas.gov

Designation Program Manager:

Elizabeth Stevenson, RN
(512) 284-1132
elizabeth.stevenson@dshs.texas.gov

Submit your application and supporting documents:

DSHS Designation Team Email Inbox
dshs.ems-trauma@dshs.texas.gov

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Trauma Facility Designation Application

Facilities requesting trauma facility designation must complete this application and submit the document to the department at DSHS.EMS-TRAUMA@dshs.texas.gov.

Date

Facility Name

Physical Street Address

City	**Zip Code**	**Trauma Service Area (TSA)**
		select

◯ **Initial Designation**

Select 'Initial Designation' if any of the following scenarios apply:

- ☐ First Time Designating as a Trauma Facility
- ☐ Designating at a Different Level Than Before
- ☐ Ownership or Physical Location has Changed (CHOW)

◯ **Re-Designation (Renewal)**

Select 'Re-Designation (Renewal)' only if renewing a designation without level change or Change of Ownership or Location (CHOW).

Current Designation Expiration Date	**Designation Level Requested**
	select

Chosen Survey Organization

ACS ◯ DSHS ◯ TETAF ◯

Texas Provider Identifier (TPI)
9-digit number issued by the Texas Medicaid & Healthcare Partnership (TMHP).

Survey Dates Requested

to

Number of HHSC-Licensed Beds

HHSC Health Facility License Number

Application Fee Payment Information

Application fee is $10/licensed bed. Levels I & II are at least $4,000 and no more than $5,000; Level III is at least $1,500 and no more than $2,500; Level IV is at least $500 and no more than $1,000.

Date Mailed	**Payment Amount**	**Check Number**

Trauma Program Manager (TPM)

Title	Name	Suffix	Credential
select		none	RN

Office Phone Number	Phone Ext	Email Address

Cell Phone Number

Trauma Medical Director (TMD)

Title	Name	Suffix	Credential
select		none	select

Email Address

CEO/Administrator/President (ADM)

Title	Name	Suffix	Credential
select		none	none

Phone Number	Phone Ext	Email Address

Position Title: select

Chief Nursing Officer (CNO)

Title	Name	Suffix	Credential
select		none	RN

Phone Number	Phone Ext	Email Address

Complete the table below, reflecting the **first year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

Complete the table below, reflecting the **second year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

Complete the table below, reflecting the **third year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

For questions, contact a member of the DSHS designation team or Jorie Klein, MSN, MHA, BSN, RN at jorie.klein@dshs.texas.gov or at 512-535-8538.

Application Electronic Signatures

Instructions:
You must open this form using a document signing program such as Adobe Reader or DocuSign in order to sign electronically. You cannot sign in a web browser. Click here for instructions on how to open the Adobe program, often installed by default with windows operating systems. Once the form is open in a document signing program, click the blue signature box to sign. Save the application and email it to your medical director and CEO. All signatures must be on one copy of the application. Please reach out to a DSHS Designation Program Specialist if you need assistance.

Trauma Program Manager E-Signature

Trauma Medical Director E-Signature

CEO/Administrator/President E-Signature

Email completed and signed form to DSHS.EMS-TRAUMA@dshs.texas.gov.

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Designation Application Fee Remittance Form

Trauma Facility Designation

Facility Name:

Physical Street Address:

City: **Zip Code:** **TSA:** select

Payment Date: **Amount Paid:** **Check Number:**

Print this page and mail it with your check to:

Texas Department of State Health Services Revenue Management Unit
Cash Receipts Branch
Mail Code 2003
P.O. Box 149347
Austin, TX 78714-9347

Make checks payable to Texas Department of State Health Services.

DSHS Cash Receipts Branch Stamp Below This Line

EMS/Trauma Systems
Consumer Protection Division
Trauma Facility Designation Program
Budget/Fund: ZZ100-160 356002