



MATERNAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

For technical assistance contact:

Designation Program Specialists

Celia Cantu (512) 231-5620

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Rebecca Wright (512) 657-0804

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For designation process or rule clarification contact:

Perinatal Designation Coordinators

Debbie Lightfoot, RN (512) 987-0565

Debra.Lightfoot@dshs.texas.gov

Dawn Thibodeau-Salazar, RN (512) 963-3410

Dawn.ThibodeauSalazar@dshs.texas.gov

Dorothy Courage, RN (512) 989-9804

Dorothy.Courage@dshs.texas.gov

Designation Program Manager

Elizabeth Stevenson, RN (512) 284-1132

Elizabeth.Stevenson@dshs.texas.gov

Your questions will be addressed by the designation staff as quickly as Submit the application packet to our office within 120 days of the facility's completed self-survey report and attestation. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration.



Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely. Ensure the facility information you are providing matches Health Facility Licensing information (form 3228).
2. Submit fee and Fee Remittance Form provided on page 6 (note: Please do not send fee without accompanying Fee Remittance Form).
3. Compile all required documents for the application packet including:
 - Completed designation application form with required signatures.
 - Copy of Fee Remittance Form sent to *Cash Receipts Branch*.
 - Perinatal Care Region (PCR) Letter of Participation.
 - Maternal self-survey report with required documents and attestation.
 - Plan of correction, including supportive documentation, if appropriate.
 - Any additional documents requested by the department.
4. Electronically submit application packet to:
DSHS.EMS-TRAUMA@dshs.texas.gov
Subject line: Maternal Application Packet: [Facility Name and PCR/TSA]
5. If you do not receive a confirmation within 2 business days, please contact a designation staff member to verify receipt of your submission.

For further information regarding the application process, go to [Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter K, §133.204 - Designation Process](#).



Maternal Facility Designation Application – Level I

Date:

Facility Name:

Licensed Street Address:

City, State, Zip:

County:

Mailing Address (if different):

City, State, Zip:

Perinatal Care Region (PCR/TSA):

Facility Level: Level I

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

DSHS Current Facility License Number:

Number of licensed beds (*from current facility license*): Texas Provider Identifier¹ (TPI) Number:

National Provider Identifier² (NPI) Number:

Fee³ amount sent to Cash Receipts Branch: \$

Check #:

Make checks payable to: Texas Department of State Health Services

Maternal Program Manager:

Title:

Phone Number(s): _____ or _____

Email:

Maternal Medical Director:

Phone:

Email:

Name of Facility CEO/President:

Title:

Phone:

Email:

¹ The Texas Provider Identifier (TPI) is a 9-character identifier issued for filing claims of reimbursement.

² The National Provider Identifier (NPI) is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS) for administrative and financial transactions.

³ Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.

Maternal Statistical Data:

Reporting period: _____ to _____
(For reporting year, use the most recent 12-month period **NOT** last calendar year, i.e. 6/1/2020 – 5/31/2021.)

Total number of all deliveries:

Total number of vaginal deliveries:

Total number of forceps deliveries:

Total number of vacuum deliveries:

Total number of TOLAC⁴ attempts:

Total number of VBAC⁵ deliveries:

Total number of Cesarean section deliveries:

Total number which were urgent cesarean:

Total number which were emergent cesarean:

Total number of multiples:

Total number of unattended deliveries:

Total number maternal patients receiving 2
units or less of blood:

Total number of hemorrhage cases:

Total number requiring 3 to 4 units of blood:

Total number requiring greater than 4 units of blood:

Total number of activated massive transfusion
protocols (MTP):

Number of pregnant patients screened for placenta
accreta spectrum disorders:

Number of deliveries of patients with placenta accreta
spectrum disorders:

⁴ Trial of Labor After Cesarean

⁵ Vaginal Birth After Cesarean

Revised October 12, 2021



Budget/Fund: ZZ101-160 355726

Fee Remittance Form

Send this form with your fee to:

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

Division: HCQSS/EMS Budget #: ZZ101
Program: Maternal Designation Fund #: 160

Application For: Maternal Facility Designation

Date:

Facility Level: Level I

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

Perinatal Care Region (PCR/TSA):

Fee⁶ Amount Enclosed:

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

Check Number (**required):

⁶Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00
Revised October 12, 2021