



## **NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I**

### **General Information**

For technical assistance contact:

#### **Designation Program Specialists**

Celia Cantu (512) 231-5620  
[Celia.Cantu@dshs.texas.gov](mailto:Celia.Cantu@dshs.texas.gov)

Rebecca Wright (512) 657-0804  
[Rebecca.Wright@dshs.texas.gov](mailto:Rebecca.Wright@dshs.texas.gov)

For designation process or rule clarification contact:

#### **Perinatal Designation Coordinators**

Debbie Lightfoot, RN (512) 987-0565  
[Debra.Lightfoot@dshs.texas.gov](mailto:Debra.Lightfoot@dshs.texas.gov)

Dawn Thibodeau-Salazar, RN (512) 963-3410  
[Dawn.ThibodeauSalazar@dshs.texas.gov](mailto:Dawn.ThibodeauSalazar@dshs.texas.gov)

Dorothy Courage, RN (512) 989-9804  
[Dorothy.Courage@dshs.texas.gov](mailto:Dorothy.Courage@dshs.texas.gov)

#### **Designation Program Manager**

Elizabeth Stevenson, RN (512) 284-1132  
[Elizabeth.Stevenson@dshs.texas.gov](mailto:Elizabeth.Stevenson@dshs.texas.gov)

Submit the application packet to the department within 120 days of the facility's completed self-survey date. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration date regardless of self-survey date.



## 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. Compile all required documents for the application packet:
  - Completed designation application form.
  - Fee with Remittance Form sent to *Cash Receipts Branch*.
  - PCR Letter of Participation.
  - Neonatal designation self-survey report with required documents and attestation.
  - Plan of correction, including supporting documentation, if appropriate.
  - Any additional documents requested by the department.
3. Submit fee with Remittance Form provided on page 5.
4. Electronically submit application packet to:  
[DSHS.EMS-TRAUMA@dshs.texas.gov](mailto:DSHS.EMS-TRAUMA@dshs.texas.gov)  
**Subject line:** Neonatal Application Packet: [Facility Name and PCR/TSA]
5. If you do not receive a confirmation within 24 working hours, 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 J, §133.184 - Designation Process](#)



## Neonatal Facility Designation Application – Level I

Date:  
Facility Name:  
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 Identifier (TPI) Number: \_\_\_\_\_  
National Provider Identifier (NPI) Number: \_\_\_\_\_

Fee amount<sup>1</sup> 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 Number: \_\_\_\_\_  
Email: \_\_\_\_\_

Name of Facility CEO/President: \_\_\_\_\_  
Title: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

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

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

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



**Neonatal Statistical Data:**

Reporting year:

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

**Level I** (Well Nursery)

Total live births for reporting period:

Total Well Nursery (or Mother-Baby) admissions for reporting period:

Total number of Well Nursery beds:

Average daily census:

Total live births <35 weeks and not transferred out:

Total neonates transferred out:

Total neonates received following delivery outside of hospital:

Total multiple births:

Total neonatal deaths:

Signature of Neonatal Program Manager                      Date

Signature of Neonatal Medical Director                      Date

Signature of CEO/President                                      Date



**Remittance Form**

*Budget/Fund: ZZ101-160 355726*

**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: Neonatal Designation        Fund #: 160

Application For: Neonatal Facility Designation

Date:

Facility Level: Level I

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

Perinatal Care Region (PCR/TSA):

Fee<sup>2</sup> Amount Enclosed:  
Make checks payable to: *Texas Department of State Health Services*  
**Check #:**

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<sup>2</sup>Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.