



NEONATAL FACILITY DESIGNATION APPLICATION LEVELS II, III, AND IV

General Information

For technical assistance contact:
Designation Program Specialists

Celia Cantu (512) 231-5620
Celia.Cantu@dshs.texas.gov

Rebecca Wright (512) 657-0804
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

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

Submit the application packet to the department within 120 days of the facility's completed survey date. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration date regardless of 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 for the appropriate level of designation.
 - Fee and Remittance Form sent to *Cash Receipts Branch*.
 - PCR Letter of Participation.
 - Neonatal designation survey report, including medical record reviews.
 - Plan of correction, including supporting documentation, if appropriate.
 - Any additional documents requested by the department.
3. Submit fee¹ with Remittance Form provided on page 7.
4. Electronically submit application packet to:
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](#)

¹Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.



Neonatal Facility Designation Application – Level II, III, and IV

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

Perinatal Care Region (PCR/TSA):

Facility Level: Level II Level III Level IV

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 Identifier² (TPI) Number:
National Provider Identifier³ (NPI) Number:

Fee amount⁴ 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:

² The Texas Provider Identifier (TPI) is a 9-character identifier issued for filing claims of reimbursement.

³ The National Provider Identifier is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS) for administrative and financial transactions.

⁴ Application fee: Level II - \$1,500.00, Level III - \$2,000.00 and Level IV - \$2,500.00.



Neonatal Statistical Data:

Reporting year:
(Use reporting period provided to survey organization.)

Level II (Special Care Nursery)

Total live births for reporting period:

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

Total number of Well Nursery beds:

Total Special Care Nursery admissions for reporting period:

Total number of Special Care Nursery beds and average daily census of SCN beds: /

Total live births ≤ 32 weeks and birth weight ≤ 1500 grams admitted:

Total neonates on assisted endotracheal ventilation > 24 hours or NCPAP until condition improved:

Total neonates/infants transferred in:

Total neonates received following delivery outside of hospital:

Total neonates transferred in from another hospital:

Total neonates/infants transferred out:

Total multiple births:

Total neonatal deaths:



Level III (Neonatal Intensive Care Unit) or **Level IV** (Advanced Neonatal ICU)

Total live births for reporting period:

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

Total number of Well Nursery beds:

Total Special Care Nursery admissions for reporting period:

Total number of Special Care Nursery beds and average daily census of SCN beds: /

Total NICU/Advanced NICU admissions for reporting period:

Total number of NICU beds and average daily census of NICU beds: /

Total number of Advanced NICU beds and average daily census of Advanced NICU beds: /

Total neonates/infants transferred in:
Total neonates received following delivery outside of hospital:
Total neonates transferred in from another hospital:

Total neonates/infants transferred out:

Total multiple births:

Total neonatal deaths:

Total number of NICU patient surgical events:

Total OR number:

Total bedside number:



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 II Level III Level IV

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

Perinatal Care Region (PCR/TSA):

Fee⁵ Amount Enclosed:
Make checks payable to: *Texas Department of State Health Services*

Check #:

⁵Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.