



TEXAS
Health and Human
Services

**Texas Department of State
Health Services**

NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I

For general department and designation questions or if you need help completing your form for technical reasons, contact:

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

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

Debbie Lightfoot, RN
(512) 987-0565
debra.lightfoot@dshs.texas.gov

Dorothy Courage, RN
(512) 939-9804
dorothy.courage@dshs.texas.gov

Casey Wasson, RN
(512) 783-6812
casey.wasson@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

Questions will be addressed by the designation team as quickly as possible.

The application packet must be submitted **within 90 days** of the date the facility completed the Self-Survey Report and Attestation Letter.

Renewal application packets must be submitted **no later than 90 days** prior to the facility's current designation expiration date.

****To use this form, you will need electronic document signing software. A free software download is available at <https://get.adobe.com/reader/>**



Application Packet Submission Instructions:

1. Save the application to your computer hard drive or cloud service.
2. Open the free Adobe software installed on your computer, then open the file downloaded to your computer using Adobe.
3. Complete the application entirely using the Adobe software.
4. *E-sign the application and save it. You cannot E-sign without Adobe.
**See page 2 of the application form for e-signature instructions*
5. Send your payment and accompanying Designation Application Fee Remittance Form* to the Revenue Management Unit, Cash Receipts Branch.
**See page 3 for payment submission instructions*
6. Compile all additional documents required to accompany your application:
Neonatal Designation Application Form
Perinatal Care Region (PCR) Letter of Participation
Neonatal Self-Survey Report
Attestation Letter
Plan of Correction, with documented evidence of implementation, if applicable
Additional documents requested by the department

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7. Email the above documents to:

dshs.ems-trauma@dshs.texas.gov

Subject line:

Neonatal Application Packet: [Facility Name and PCR]

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8. If you do not receive a response confirming receipt of your submission, please contact a designation team member to ensure it has been received.

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:

Physical Street Address:

City:

Zip Code:

Perinatal Care Region (PCR):

Initial Designation

Select 'Initial Designation' if the following scenarios apply:

First Time Designating as a Neonatal 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/
Location (CHOW).

Number of DSHS Licensed Beds:

License Number:

Your License Number is a 6-digit number found on your
Health Facility License issued by DSHS.

Date Payment was Mailed:

Check Number:

Payment Amount:

Application Fee is \$250 for ≤ 100 licensed bed facilities; and
\$750 for > 100 licensed bed facilities.

Designation Expiration Date:

If currently designated.

TPI:

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

NPI:

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

Neonatal Program Manager

Title: Name: Suffix: Credential:

Phone Number: Email Address:

Neonatal Medical Director

Title: Name: Suffix: Credential:

Email Address:

CEO/Administrator

Title: Name: Suffix: Credential:

Phone Number: Email Address:

Job Position Title:



Reporting period: _____ to _____
Use the most recent 12-month period (ex. 06/01/2022 to 05/31/2023).

List the total number of patients who meet the criteria below in the right-hand column.

Live births:	
Well Nursery (or Mother-Baby) admissions:	
Bed Count:	
Average Daily Census:	
Total live births less than 35 weeks gestational age and not transferred out:	
Neonates transferred out to external facilities:	
Neonates admitted after delivery outside of the hospital:	
Multiple births:	
Neonatal deaths:	

Neonatal Program Manager Signature

CEO/Administrator Signature

Neonatal Medical Director Signature

***E-Signature Instructions:**

Click the blue signature box to sign electronically. Save the application and email it to your medical director and CEO. All signatures should be on one copy of the application.

Please do not submit a printed and scanned version of the application.

Are you having trouble?

Click [here](#) for more instructions.



Facility Name:

Physical Street Address:

City:

County:

Zip Code:

PCR:

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
Neonatal Designation Program
Budget/Fund: ZZ101-160 355726**