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

NEONATAL FACILITY DESIGNATION APPLICATION

LEVEL II - IV

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 site survey date.

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/**

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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 Site Survey Summary, with Medical Record Reviews
- ☐ Plan of Correction, with documented evidence of implementation, if applicable
- ☐ Additional documents requested by the department

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 more information regarding the application process, go to:

Texas Administration Code, Title 25, Part 1, Chapter 133, Subchapter J, Rule §133.184 *Designation Process*

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Neonatal Facility Designation Application - Levels II - IV

Date:

Facility Name:

Physical Street Address:

City: Zip Code: Perinatal Care Region (PCR): select

○ Initial Designation Designation Level: select

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: select

Application Fee for Level II is $1,500; Level III is $2,000 ; Level IV is $2,500.

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: select Name: Suffix: (none) Credential: RN

Phone Number: Email Address:

Neonatal Medical Director

Title: select Name: Suffix: (none) Credential: select

Email Address:

CEO/Adminstrator

Title: select Name: Suffix: (none) Credential: select

Phone Number: Email Address:

Job Position Title: select

Reporting period: _____ to _____

Use the data from the 12-month period which corresponds with your most-recent survey.

Level II – IV Facility Applicants *List the total number of patients who meet the criteria below in the right-hand column.*	
Live births:	
Well Nursery (Mother-Baby) admissions:	
Bed count:	
Special Care Nursery admissions:	
Bed count:	
Average daily census:	
Neonates/infants transferred in:	
From another hospital:	
Received after delivery outside of the hospital:	
Neonates/infants transferred out:	
Multiple births:	
Neonatal deaths:	

Level II Facility Applicants ONLY *List the total number of patients who meet the criteria below in the right-hand column.*	
Live births less than or equal to 32 weeks **and** birth weight less than or equal to 1500 grams admitted:	
Neonates on assisted endotracheal ventilation greater than 24 hours or NCPAP until condition improved:	

Level III – IV Facility Applicants ONLY *List the total number of patients who meet the criteria below in the right-hand column.*	
NICU/Advanced NICU admissions:	
Bed count:	
Average daily census:	
NICU patient surgical events:	
In the Operating Room:	
At the bedside:	

Neonatal Program Manager Signature

Neonatal Medical Director Signature

CEO/Administator Signature

***E-Signature Instructions:**
Ensure the form is open in adobe or another document signing program. Click the blue signature box to sign electronically. The form cannot be signed in a web browser. All signatures should be on one copy of the application.

Facility Name:

Physical Street Address:

City: County: Zip Code: PCR: select

Payment Date: Amount Paid: select 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