TEXAS DEPARTMENT OF STATE HEALTH SERVICES
EMS/Trauma Systems Section Revised 09/14/2022

Stroke Facility Designation Application
All Levels

Date: _____

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

Trauma Service Area (TSA): _____
License Number: _____ Number of licensed beds: _____

Facility Level: Level I ☐ Level II ☐ Level III ☐ Level IV ☐

☐ **Initial Designation**
☐ Change of Ownership/Location (CHOW) ☐ Designation Level Change

☐ **Re-Designation** **Expiration Date of Designation:** _____

Stroke Certification Agency: **TJC** ☐ **DNV-GL** ☐ **TETAF** ☐ **CIHQ** ☐ **HFAP** ☐

Certification Expiration Date: _____

Stroke Program Manager: _____
Phone Number(s): _____ or _____
Email: _____

Stroke Medical Director: _____
Phone Number: _____
Email: _____

Chief Nursing Officer: _____
Phone Number(s): _____ or _____
Email: _____

Facility CEO/President: _____
Title: _____
Phone: _____
Email: _____

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Facility Name: _____ TSA: _____

Statistical Data:

- Reporting year: _____ to _____
  Choose the most recent facility annual reporting period (ex. calendar or fiscal year).

- Total Emergency Department (ED) visits for reporting year: _____
  Include Dead on Arrival (DOA) and Died in ED (DIE)

- Total number of stroke-related ED visits: _____
-
- Total number of stroke-related deaths in the ED: _____

- Number of stroke related admissions:

ED to Intensive Care Unit	
ED to Med/Surg Unit	
Inpatient Deaths	
Total	

- Number of stroke related transfers:

Transfer In - Air	
Transfer In - Ground	
Transfer Out - Air	
Transfer Out - Ground	

_____ _____
Signature of Stroke Program Manager Date

_____ _____
Signature of Stroke Medical Director Date

_____ _____
Signature of CEO/President Date

Budget/Fund: ZZ100-161 356007

Remittance Form

Mail this form with your fee to:

Revenue Management Unit –
Cash Receipts Branch Texas Department of State Health Services
Mail Code 1989
P.O. Box 149347
Austin, Texas 78714-9347

Division: CP/EMS Budget #: ZZ100
Program: Stroke Fund #: 161

Application For: Stroke Facility Designation

Date: _____

Facility Level: Level I ☐ Level II ☐ Level III ☐ Level IV ☐

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

Trauma Service Area (TSA): _____

Fee Amount Enclosed: $100.00 ***Check Number***: _____
Make checks payable to: *Texas Department of State Health Services*

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
EMS/Trauma Systems Section

Revised 09/13/2022

Facility Name: _____ TSA: ____

Designation Application Packet Checklist

Submit the following documents electronically:**

- ☐ Completed Stroke Facility Designation application.
- ☐ ***Copy*** of the Remittance Form sent to "Cash Receipts Branch" including the check number.
- ☐ The RAC Letter of Participation (must not be more than 180 days old).
- ☐ Most recent annual summary of the Stroke Quality Assessment and Performance Improvement Plan.
- ☐ Stroke designation site survey summary including the requirement compliance findings and medical record summaries.
- ☐ Evidence of successful certification issued by the survey organization.
- ☐ Plan of Correction (POC) for all requirements with identified non-compliance findings.

Electronically submit to: DSHS.EMS-TRAUMA@dshs.texas.gov

****Completed application must be submitted no later than 60 days after the site survey date but at least 90 days before current designation expiration.**