TEXAS Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

STROKE FACILITY DESIGNATION APPLICATION

For general department or designation questions, contact a Designation Program Specialist:

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

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

Audrey Green, RN
(512) 605-9108
audrey.green@dshs.texas.gov

Katie Foarde, RN
(737) 354-1849
katie.foarde@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 **no later than 60 days** after the site survey date.

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

****To use this form, you will need a free file viewer published by Adobe. Visit this website to download https://get.adobe.com/reader/**

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

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:

- ☐ Stroke Facility Designation Application Form
- ☐ Regional Advisory Council (RAC) Letter of Participation
- ☐ Stroke Site Survey Summary, including requirements met findings and medical record summaries
- ☐ Most recent annual summary of the Stroke Quality Assessment and Performance Improvement (QAPI) Plan
- ☐ Evidence of successful certification issued by a survey organization (excluding TETAF surveys)
- ☐ Plan of Correction for all requirements not met, if applicable
- ☐ Additional documents requested by the department

7. Email the above documents to: **dshs.ems-trauma@dshs.texas.gov**

   Subject line:

   Stroke Application Packet: [Facility Name and TSA]

7. 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 157, Subchapter G, §157.133 Requirements for Stroke Facility Designation

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

Stroke Facility Designation Application

Date:

Facility Name:

Physical Street Address:

City: Zip Code: Trauma Service Area (TSA): select

○ Initial Designation

Select 'Initial Designation' if the following scenarios apply:

- ☐ First Time Designating as a Stroke 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).*

Designation Expiration Date:
If currently designated.

Designation Level: select

Stroke Certification Agency: select

Number of DSHS Licensed Beds:

Date Payment was Mailed:

License Number:

Check Number:

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

Payment Amount: $100.00

Stroke Program Manager

Title: select Name: Suffix: none Credential: RN

Phone Number: Email Address:

Chief Nursing Officer

Title: select Name: Suffix: none Credential: RN

Phone Number: Email Address:

Stroke 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

Stroke Statistical Data

Reporting period: _____ to _____

Use the facility's most recent annual reporting period (ex. calendar or fiscal year).

List the total number in each category for the above reporting year in the right-hand column.	
Annual ED Visits:	
Annual ED Stroke Team Alerts:	
Annual Stroke Admissions:	
Stroke-related Transfers In:	
Ground:	
Air:	
Stroke-related Transfers Out:	
Ground:	
Air:	

_____
Stroke Program Manager Signature

_____
Stroke Medical Director Signature

_____
CEO/President 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: TSA: select

Payment Date: Amount Paid: $100.00 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
Stroke Facility Designation Program
Budget/Fund: ZZ100-161 356007