



**TEXAS**  
Health and Human  
Services

**Texas Department of State  
Health Services**

## **TRAUMA FACILITY DESIGNATION APPLICATION**

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

Rebecca Dimas  
(512) 657-0804  
[rebecca.wright@dshs.texas.gov](mailto:rebecca.wright@dshs.texas.gov)

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

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

Katie Foarde, RN  
(737) 354-1849  
[katie.foarde@dshs.texas.gov](mailto:katie.foarde@dshs.texas.gov)

**Designation Program Manager:**

Elizabeth Stevenson, RN  
(512) 284-1132  
[elizabeth.stevenson@dshs.texas.gov](mailto:elizabeth.stevenson@dshs.texas.gov)

**Submit your application and supporting documents:**

DSHS Designation Team Email Inbox  
[dshs.ems-trauma@dshs.texas.gov](mailto:dshs.ems-trauma@dshs.texas.gov)



Trauma Facility Designation Application

Facilities requesting trauma facility designation must complete this application and submit the document to the department at [DSHS.EMS-TRAUMA@dshs.texas.gov](mailto:DSHS.EMS-TRAUMA@dshs.texas.gov).

Date

Facility Name			
Physical Street Address			
City	Zip Code	Trauma Service Area (TSA)	
Initial Designation			
Select 'Initial Designation' if any of the following scenarios apply:			
First Time Designating as a Trauma 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 or Location (CHOW).			
Current Designation Expiration Date		Designation Level Requested	
Chosen Survey Organization		Texas Provider Identifier (TPI)	
ACS      DSHS      TETAF		9-digit number issued by the Texas Medicaid & Healthcare Partnership (TMHP).	
Survey Dates Requested			
to			
Number of HHSC-Licensed Beds		HHSC Health Facility License Number	
Application Fee Payment Information			
Application fee is \$10/licensed bed. Levels I & II are at least \$4,000 and no more than \$5,000; Level III is at least \$1,500 and no more than \$2,500; Level IV is at least \$500 and no more than \$1,000.			
Date Mailed	Payment Amount	Check Number	



## Designation Program Contacts

<b><i>Trauma Program Manager (TPM)</i></b>			
Title	Name	Suffix	Credential
Office Phone Number	Phone Ext	Email Address	
Cell Phone Number			
<b><i>Trauma Medical Director (TMD)</i></b>			
Title	Name	Suffix	Credential
Email Address			
<b><i>CEO/Administrator/President (ADM)</i></b>			
Title	Name	Suffix	Credential
Phone Number	Phone Ext	Email Address	
Position Title:			
<b><i>Chief Nursing Officer (CNO)</i></b>			
Title	Name	Suffix	Credential
Phone Number	Phone Ext	Email Address	



## Trauma Program Statistics

Complete the table below, reflecting the **first year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

Complete the table below, reflecting the **second year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

Complete the table below, reflecting the **third year of designation cycle**.

ISS Review	Total Patient Meeting NTDB criteria in Registry	ED to OR	ED to ICU Admissions	ED Transferred Out	All Deaths
0-9					
10-15					
16-24					
≥25					
Total Patients					

For questions, contact a member of the DSHS designation team or Jorie Klein, MSN, MHA, BSN, at [jorie.klein@dshs.texas.gov](mailto:jorie.klein@dshs.texas.gov) or at 512-535-8538.



## **Application Electronic Signatures**

### **Instructions:**

You must open this form using a document signing program such as Adobe Reader or DocuSign in order to sign electronically. You cannot sign in a web browser. Click [here](#) for instructions on how to open the Adobe program, often installed by default with windows operating systems. Once the form is open in a document signing program, click the blue signature box to sign. Save the application and email it to your medical director and CEO. All signatures must be on one copy of the application. Please reach out to a DSHS Designation Program Specialist if you need assistance.

### **Trauma Program Manager E-Signature**

### **Trauma Medical Director E-Signature**

### **CEO/Administrator/President E-Signature**

Email completed and signed form to DSHS.EMS-TRAUMA@dshs.texas.gov.



**Designation Application Fee  
Remittance Form**

*Trauma Facility Designation*

**Facility Name:**

**Physical Street Address:**

**City:**

**Zip Code:**

**TSA:**

**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**

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**EMS/Trauma Systems  
Consumer Protection Division  
Trauma Facility Designation Program  
Budget/Fund: ZZ100-160 356002**