MATERNAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, process, or rule clarification, please contact:
- **Perinatal Designation Coordinators**

  Debbie Lightfoot, RN – (512) 231-5614
  Debra.Lightfoot@DSHS.texas.gov

  Danielle Vargas, R.N. – (737) 218-7069
  Danielle.Vargas@DSHS.texas.gov

- **Designation Program Manager**

  Elizabeth Stevenson, RN – (512) 834-6794
  Elizabeth.Stevenson@DSHS.texas.gov

- Submit the application packet to our office within 120 days of the facility's completed self-survey report and attestation.
- For further information regarding the application process, go to Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter K, §133.204 - Designation Process

TEXAS Health and Human Services

Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely.

2. Compile all required documents for the application packet: application, payment, Self Survey Report, Plan of Correction (POC), Perinatal Care Region (PCR) participation letter, and any subsequent documents requested by the office.

3. Submit payment[1] and Remittance Form to:

   Texas Department of State Health Services
   Cash Receipts Branch, MC 2003
   Office of EMS/Trauma Systems Coordination
   P.O. Box 149347
   Austin, Texas 78714-9347

4. Electronically submit application packets to:

   DSHS.EMS-TRAUMA@dshs.state.tx.us

   Subject line: Maternal Application Packet: [Facility Name and PCR/TSA]

   - If unable to submit electronically, send via:

     US Postal Service:
     Department of State Health Services
     Office of EMS/Trauma Systems, MC1876
     P. O. Box 149347
     Austin, TX 78714-9347

     Other services (i.e. UPS or FedEx), or hand-delivery:
     Department of State Health Services
     Office of EMS/Trauma Systems, MC1876
     8407 Wall Street
     Austin, TX 78754

[1] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

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Maternal Facility Designation Application – Level I

Date: _____

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

License Number: _____ Number of licensed beds: _____
Texas Provider Identifier[2]: _____
National Provider Identifier[3] Number: _____
Perinatal Care Region (PCR/TSA): ---CHOOSE---

Fee[4] sent to the Cash Receipts Branch with Remittance form: _____

Facility Level: Level I

☐ Initial Designation
☐ Change of Ownership/Location (CHOW) ☐ Designation Level Change
☐ Re-Designation Expiration Date: _____

Maternal Program Manager: _____
Title: _____
Phone Number(s): _____ or _____
Email: _____

Maternal Medical Director: _____
Phone Number: _____
Email: _____

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

Signature of CEO/President: _____ Date: _____

[2] *The Texas Provider Identifier (TPI) is a 9-character identifier issued for filing claims of reimbursement.*
[3] *The National Provider Identifier is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS) for administrative and financial transactions.*
[4] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

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Maternal Statistical Data:

Reporting month/year (mm/yy):_____ to _____
(Use the most recent 12-month period, i.e. 04/17 to 04/18)

Total number of vaginal deliveries: _____
Total number of forceps deliveries: _____
Total number of vacuum deliveries: _____

Total number of TOLAC[5] attempts: _____
Total number of VBAC[6] deliveries: _____

Total number of C-section deliveries: _____

Total number of multiples: _____

Total number of postpartum hemorrhage cases: _____

Total number of perinatal ICU admissions: _____

Total number of maternal-related deaths: _____

Total number of maternal transfers in from external facilities: _____
Total number denied: _____

Total number of maternal transfers out to external facilities: _____
Total number denied: _____

_____ _____
Signature of Maternal Program Manager Date

_____ _____
Signature of Maternal Medical Director Date

[5] *Trial of Labor After Cesarean*
[6] *Vaginal Birth After Cesarean*

Remittance Form

Send this form with your payment to:

Texas Department of State Health Services
Cash Receipts Branch, MC 2003
Office of EMS/Trauma Systems
P.O. Box 149347
Austin, Texas 78714-9347

Division: HCQSS/EMS Budget #: ZZ101
Program: Maternal Designation Fund #: 160

Application For: Maternal Facility Designation

Date _____

Facility Level: Level I

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

Perinatal Care Region (PCR/TSA): ---CHOOSE---

Fee[7] Amount Enclosed: _____
Make checks payable to: *Texas Department of State Health Services*
Check Number: _____

[7] *Application fee: Level I ≤100 licensed beds - $250.00; or >100 licensed beds - $750.00.*

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Required Documents:

- ☐ Completed designation application form.
- ☐ Copy of the Remittance Form sent to *Cash Receipts* with payment.
- ☐ PCR Letter of Participation.
- ☐ Completed maternal self survey report with appropriate requested documents.
- ☐ Completed attestation form.
- ☐ Plan of correction if appropriate.
- ☐ Any subsequent documents requested by the office.