



NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, please contact:

Shyriecce Norris – (512) 231-5748
Shyriecce.Norris@dshs.texas.gov

Courtney Ennis – (512) 289-1867
Courtney.Ennis@dshs.texas.gov

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

Debbie Lightfoot, RN – (512) 987-0565
Debra.Lightfoot@dshs.texas.gov

Johanna Wynn, RN – (512) 632-8743
Johanna.Wynn@dshs.texas.gov

Kathie Stephens, RN – (512) 987-0638
Kathie.Stephens@dshs.texas.gov

Designation Program Manager

Elizabeth Stevenson, RN – (512) 284-1132
Elizabeth.Stevenson@dshs.texas.gov

- Submit the application packet to the department within 120 days of the facility's completed self-survey date. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration date regardless of self-survey date.



Application Packet Submission Instructions:

1. Fill out the Application. Answer all questions completely. Ensure the facility information you are providing matches Health Facility Licensing information (form 3228).
2. Compile all required documents for the application packet:
 - Completed designation application form.
 - Fee with Remittance Form sent to *Cash Receipts Branch*.
 - PCR Letter of Participation.
 - Neonatal designation self-survey report with required documents and attestation.
 - Plan of correction, including supporting documentation, if appropriate.
 - Any additional documents requested by the department.
3. Submit fee with Remittance Form provided on page 5.
4. Electronically submit application packet to:
DSHS.EMS-TRAUMA@dshs.texas.gov
Subject line: Neonatal Application Packet: [Facility Name and PCR/TSA]
5. If you do not receive a confirmation within 24 working hours, please contact a designation staff member to verify receipt of your submission.

For further information regarding the application process, go to [Texas Administrative Code Title 25, Part 1, Chapter 133, Subchapter J, §133.184 - Designation Process](#)



Neonatal Facility Designation Application – Level I

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

Perinatal Care Region (PCR/TSA):

Facility Level: Level I

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

DSHS Current Facility License Number:
Number of licensed beds (*from current facility license*): _____
Texas Provider Identifier (TPI) Number: _____
National Provider Identifier (NPI) Number: _____

Fee amount¹ sent to the Cash Receipts Branch: \$ _____

Check #:

* Make checks payable to: *Texas Department of State Health Services*

Neonatal Program Manager:

Title: _____
Phone Number(s): _____ or _____
Email: _____

Neonatal Medical Director: _____
Phone Number: _____
Email: _____

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

¹ The Texas Provider Identifier (TPI) is a 9-character identifier issued for filing claims of reimbursement.

² The National Provider Identifier is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS) for administrative and financial transactions.

³ Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.



Neonatal Statistical Data:

Reporting year:

*(For reporting year, use the most recent 12-month period **NOT** last calendar year, i.e. 6/1/2020 – 5/31/2021)*

Level I (Well Nursery)

Total live births for reporting period:

Total Well Nursery (or Mother-Baby) admissions for reporting period:

Total number of Well Nursery beds:

Average daily census:

Total live births <35 weeks and not transferred out:

Total neonates transferred out:

Total neonates received following delivery outside of hospital:

Total multiple births:

Total neonatal deaths:

Signature of Neonatal Program Manager Date

Signature of Neonatal Medical Director Date

Signature of CEO/President Date



Remittance Form

Budget/Fund: ZZ101-160 355726

Send this form with your fee to:

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

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

Application For: Neonatal Facility Designation

Date:

Facility Level: Level I

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

Perinatal Care Region (PCR/TSA):

Fee² Amount Enclosed:
Make checks payable to: *Texas Department of State Health Services*
Check #:

²Application fee: Level I ≤100 licensed beds - \$250.00; or >100 licensed beds - \$750.00.