MATERNAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, please email:
  DSHS.EMS-TRAUMA@dshs.texas.gov
  Your questions will be addressed by the designation staff as quickly as possible.

- For process or rule clarification, please contact:

  Perinatal Designation Coordinators

  Debbie Lightfoot, R.N. – (512) 987-0565

  Debra.Lightfoot@dshs.texas.gov

  Kathie Stephens, R.N. - (512) 987-0638

  Kathie.Stephens@dshs.texas.gov

  Designation Program Manager

  Elizabeth Stevenson, R.N. – (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. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration.

TEXAS Health and Human Services

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. Submit fee and Fee Remittance Form provided on page 6 (note: Please do not send fee without accompanying Fee Remittance Form).

3. Compile all required documents for the application packet including:

- ☐ Completed designation application form with required signatures.
- ☐ Copy of Fee Remittance Form sent to *Cash Receipts Branch*.
- ☐ Perinatal Care Region (PCR) Letter of Participation.
- ☐ Maternal self-survey report with required documents and attestation.
- ☐ Plan of correction, including supportive documentation, if appropriate.
- ☐ Any additional documents requested by the department.

4. Electronically submit application packet to:

   DSHS.EMS-TRAUMA@dshs.texas.gov
   Subject line: Maternal Application Packet: [Facility Name and PCR/TSA]

5. If you do not receive a confirmation within 2 business days, 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 K, §133.204 - Designation Process.

TEXAS Health and Human Services

Maternal Facility Designation Application – Level I

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

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

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[1] (TPI) Number: _____
National Provider Identifier[2] (NPI) Number: _____

Fee[3] amount sent to Cash Receipts Branch: $ _____
Check #: _____
Make checks payable to: Texas Department of State Health Services

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

Maternal Medical Director: _____
Phone: _____
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 (NPI) 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.

TEXAS Health and Human Services

Maternal Statistical Data:

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

Total number of all deliveries: _____

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

Total number of TOLAC[4] attempts: _____
Total number of VBAC[5] deliveries: _____

Total number of Cesarean section deliveries: _____
Total number which were urgent cesarean: _____
Total number which were emergent cesarean: _____

Total number of multiples: _____

Total number of unattended deliveries: _____

Total number maternal patients receiving 2 units or less of blood: _____

Total number of hemorrhage cases: _____
Total number requiring 3 to 4 units of blood: _____
Total number requiring greater than 4 units of blood: _____

Total number of activated massive transfusion protocols (MTP): _____

Number of pregnant patients screened for placenta accreta spectrum disorders: _____

Number of deliveries of patients with placenta accreta spectrum disorders: _____

[4] Trial of Labor After Cesarean
[5] Vaginal Birth After Cesarean

Number of placenta accreta spectrum team simulation trainings per year: _____

Number of deliveries with placenta previa: _____

Number of deliveries with placental abruption: _____

Number of deliveries with uterine rupture: _____

Number of perinatal ICU admissions: _____

Number of maternal-related deaths: _____

Total neonatal deaths related to maternal intrapartum or delivery complications: _____

Number of maternal transfers **in from** external facilities: _____

Number of maternal transfers **out to** external facilities: _____

_____ _____
Signature of Maternal Program Manager Date

_____ _____
Signature of Maternal Medical Director Date

_____ _____
Signature of CEO/President Date

Budget/Fund: ZZ101-160 355726

Fee Remittance Form

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: Maternal Designation Fund #: 160

Application For: Maternal Facility Designation

Date: _____

Facility Level: Level I

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

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

Fee[6] Amount Enclosed: _____

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

Check Number (**required): _____

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