



MATERNAL FACILITY DESIGNATION APPLICATION LEVELS II, III, AND IV

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) 284-1132
Elizabeth.Stevenson@dshs.texas.gov
- Submit the application packet to our office within 120 days of the facility's completed survey date. If renewal of designation, packet must be submitted **no later than** 60 days prior to expiration date regardless of 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. 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 for the appropriate level of designation with required signatures.
 - Copy of Fee Remittance Form sent to *Cash Receipts Branch*.
 - Perinatal Care Region (PCR) Letter of Participation.
 - Maternal designation survey report, including medical record reviews.
 - Plan of correction, including supporting 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](#).



Maternal Statistical Data:

Reporting period: _____ to _____
(Use reporting period provided to survey organization.)

Total number of all deliveries:

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

Total number of TOLAC⁴ attempts:
Total number of VBAC⁵ 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:

Number of placenta accreta spectrum team simulation
trainings per year:

⁴ Trial of Labor After Cesarean
⁵ Vaginal Birth After Cesarean
Revised October 12, 2021



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 II Level III Level IV

Facility Name:

Licensed Street Address:

City, State, Zip:

County:

Perinatal Care Region (PCR/TSA):

Fee⁶ Amount Enclosed:

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

Check Number (**required):

⁶Application fee: Level II - \$1,500.00, Level III - \$2,000.000 and Level IV - \$2,500.00.
Revised October 12, 2021