NEONATAL FACILITY DESIGNATION APPLICATION LEVEL I

General Information

- For technical assistance, please contact:

  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

  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.

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. 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

TEXAS Health and Human Services

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): --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 (TPI) Number: _____
National Provider Identifier (NPI) Number: _____

Fee amount[1] 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.*

TEXAS Health and Human Services

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): --Choose--

Fee[2] Amount Enclosed: _____
Make checks payable to: *Texas Department of State Health Services*
Check #: _____

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