TEXAS Health and Human Services

Texas Department of State Health Services

Jennifer A. Shuford, M.D., M.P.H.
Commissioner

MATERNAL FACILITY DESIGNATION APPLICATION LEVELS II - IV

For general department and designation questions or if you need help completing your form for technical reasons contact a Designation Program Specialist:

Celia Cantu
(512) 231-5620
celia.cantu@dshs.texas.gov

Rebecca Wright (technical assistance contact)
(512) 657-0804
rebecca.wright@dshs.texas.gov

For designation process or rule clarification, contact a Perinatal Designation Coordinator:

Debbie Lightfoot, RN
(512) 987-0565
debra.lightfoot@dshs.texas.gov

Dorothy Courage, RN
(512) 939-9804
dorothy.courage@dshs.texas.gov

Designation Program Manager:

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

Submit your application and supporting documents:

DSHS Designation Team Email Inbox
dshs.ems-trauma@dshs.texas.gov

Questions will be addressed by the designation team as quickly as possible.

The application packet must be submitted **within 90 days** of the site survey date.

Renewal application packets must be submitted **no later than 90 days** prior to the facility's current designation expiration date.

****To use this form, you will need a free file viewer published by Adobe . Visit this website to download https://get.adobe.com/reader/**

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Application Packet Submission Instructions:

1. Save the application to your computer hard drive or cloud service.
2. Open the free Adobe Reader software installed on your computer, then open the file downloaded to your computer using Adobe.
3. Complete the application entirely using the Adobe software.
4. *E-sign the application and save it. You cannot E-sign without Adobe.
   **See page 2 of the application form for e-signature instructions*
5. Send your payment and accompanying Designation Application Fee Remittance Form* to the Revenue Management Unit, Cash Receipts Branch.
   **See page 3 of the application form for payment submission instructions*
6. Compile all additional documents required to accompany your application:

- ☐ Maternal Facility Designation Application Form
- ☐ Perinatal Care Region (PCR) Letter of Participation
- ☐ Maternal Site Survey Summary, with Medical Record Reviews
- ☐ Plan of Correction, with documented evidence of implementation, if applicable
- ☐ Additional documents requested by the department

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7. Email the above documents to: **dshs.ems-trauma@dshs.texas.gov**

   Subject line:

   Maternal Application Packet: [Facility Name and PCR]

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8. If you do not receive a response confirming receipt of your submission, please contact a designation team member to ensure it has been received.

For further information regarding the application process, go to:

Texas Administration Code, Title 25, Part 1, Chapter 133, Subchapter K, §133.204 *Designation Process*

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Maternal Facility Designation Application - Levels II - IV

Date:

Facility Name:

Physical Street Address:

City: Zip Code: Perinatal Care Region (PCR): select

○ Initial Designation Designation Level: select

Select 'Initial Designation' if the following scenarios apply:

- ☐ First Time Designating as a Maternal Facility
- ☐ Designating at a Different Level Than Before
- ☐ Ownership or Physical Location has Changed *(CHOW)*

○ Re-Designation (Renewal)

*Select 'Re-Designation (Renewal)' **only** if renewing a designation without level change or Change of Ownership/ Location (CHOW).*

Number of DSHS Licensed Beds:

License Number:

Your License Number is a 6-digit number found on your Health Facility License issued by DSHS.

Date Payment was Mailed:

Check Number:

Payment Amount: select

Application fee for Level II is $1,500; Level III is $2,000; and Level IV is $2,500.

Designation Expiration Date:

If currently designated.

TPI:

The Texas Provider Identifier (TPI) is a 9-digit number issued by Texas Medicaid & Healthcare Partnership (TMHP).

NPI:

The National Provider Identifier (NPI) is a 10-digit number issued by the Centers for Medicare & Medicaid Services (CMS).

Maternal Program Manager

Title: select Name: Suffix: (none) Credential: RN

Phone Number: Email Address:

Maternal Medical Director

Title: select Name: Suffix: (none) Credential: select

Email Address:

CEO/Adminstrator

Title: select Name: Suffix: (none) Credential: select

Phone Number: Email Address:

Job Position Title: select

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Maternal Statistical Data

Reporting period: _____ to _____

Use data from the 12-month period which corresponds with your most-recent survey.

List the total number of patients who meet the criteria below in the right-hand column.

All deliveries:	
Vaginal deliveries:	
with forceps:	
with vacuum:	
Cesarean sections:	
Urgent cesarean sections:	
Emergent cesarean sections:	
Multiples:	
Trial of Labor After Cesarean (TOLAC) attempts:	
Successful Vaginal Births After Cesarean (VBAC):	
Deliveries unattended by physician or advanced practice provider:	
Hemorrhage cases:	
Patients requiring 1 to 2 units of blood:	
Patients requiring 3 to 4 units of blood:	
Patients requiring greater than 4 units of blood: *Exclude MTP cases*	
Activated Massive Transfusion Protocols (MTP):	
Patients delivered with Placenta Accreta Spectrum Disorder (PASD):	
Patients delivered with Placenta Previa:	
Patients with placental abruption:	
Patients with uterine rupture:	
Any re-admission of a maternal patient within 30 days of discharge	
Perinatal ICU admissions:	
Maternal-related deaths:	
Fetal & neonatal deaths related to intrapartum care or delivery complications:	
Maternal transfers in from external facilities: *includes birthing centers, home births, and other healthcare facilities.*	
Maternal transfers out to external facilities:	

Maternal Program Manager Signature

CEO/Administrator Signature

Maternal Medical Director Signature

***E-Signature Instructions:**
Click the blue signature box to sign electronically. Save the application and email it to your medical director and CEO. All signatures should be on one copy of the application.

Please do not submit a printed and scanned version of the application.

Are you having trouble?
Click **here** for more instructions.

Facility Name:

Physical Street Address:

City: County: Zip Code: PCR: select

Payment Date: Amount Paid: select Check Number:

***Print this page and mail it with your check to:**

Texas Department of State Health Services
Revenue Management Unit
Cash Receipts Branch
Mail Code 2003
P.O. Box 149347
Austin, TX 78714-9347

Make checks payable to Texas Department of State Health Services

DSHS Cash Receipts Branch Stamp Below This Line

EMS/Trauma Systems
Consumer Protection Division
Maternal Facility Designation Program
Budget/Fund: ZZ103-160 356009