**General information:**

Healthcare facilities seeking trauma designation and using the American College of Surgeons (ACS) survey process shall complete this application and submit it in its entirety to the Office of EMS/Trauma Systems Coordination (OEMS/TS).

* A copy of the ACS Pre-Review Questionnaire must be submitted to OEMS/TS no later than 30 days prior to the facility's ACS survey.

**Timely and Sufficient Application:**
Excerpts from Trauma Facility Designation Rule §157.125

*(d) For a facility seeking **INITIAL designation**, a timely and sufficient application shall include:*

*(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office;*
*(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;*
*(3) any subsequent documents submitted by the date requested by the office;*
*(4) a trauma designation survey completed within one year of the date of the receipt of the application by the office; and*
*(5) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office.*

*(e) If a hospital seeking initial designation fails to meet the requirements in subsection (d)(1) - (5) of this section, the application shall be denied.*

*(f) For a facility seeking **RE-DESIGNATION**, a timely and sufficient application shall include:*

*(1) the department's current "Complete Application" form for the appropriate level, with all fields correctly and legibly filled-in and all requested documents attached, hand-delivered or sent by postal services to the office one year or greater from the designation expiration date;*
*(2) full payment of the designation fee enclosed with the submitted "Complete Application" form;*
*(3) any subsequent documents submitted by the date requested by the office; and*
*(4) a complete survey report, including patient care reviews, that is within 180 days of the date of the survey and is hand-delivered or sent by postal services to the office no less than 60 days prior to the designation expiration date.*

*(g) If a healthcare facility seeking re-designation fails to meet the requirements outlined in subsection (f)(1) - (4) of this section, the original designation will expire on its expiration date.*

**Technical Assistance:** Whom do I call for information or guidance while completing the application?

**Answer:** For content or clarification of questions, please call or email us at:

Gina Pickard – 512/834-6700 ext. 2457
gina.pickard@dshs.state.tx.us

For *Technical* Difficulties call Terri Vernon (512) 834-6700 ext. 2375
terri.vernon@dshs.state.tx.us

# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

## Application Submission Instructions: (for initial and re-designation)

1. Fill out the *"Complete Trauma Facility Designation Application."* Answer all questions completely and enclose attachments as necessary. If a question does not apply to your facility, answer with "n/a" (*not applicable*). Narrative answers may be attached as separate documents to the application.

2. **STEP A:** Submit the following documents:

   - two (2) copies of the *"Complete Trauma Facility Designation Application."*
   - the application fee: *$10.00 per licensed bed **
     - * *$4,000 minimum fee / $5,000 maximum fee for Level I and II*
     - * *$1,500 minimum fee / $2,500 maximum fee for Level III*
   - a current letter from the Regional Advisory Council (RAC) with which the facility is affiliated confirming facility participation in RAC activities.

   **STEP B:** Additionally, submit:

   - two (2) copies of the completed ACS Pre-Review Questionnaire 30 days prior to your scheduled ACS visit.

3. Submit the required documents to:

   Cash Receipts Branch, MC 2003
   Department of State Health Services
   Office of EMS/Trauma Systems Coordination
   Attn: Trauma Designation Program
   1100 West 49th Street
   P.O. Box 149347
   Austin, TX 78714-9347

Budget/Fund: ZZ100-160 356002

# TEXAS DEPARTMENT OF STATE HEALTH SERVICES

**Cash Receipts Branch, MC2003**
**Office of EMS/Trauma Systems Coordination**
**1100 West 49th Street**
**PO Box 149347**
**Austin, TX 78714-9347**

## Complete Trauma Facility Designation Application

***For Hospitals using the American College of Surgeons Verification Process***

**STEP A:** Date: _____

Designation Level Applying for: ☐ **Level I** ☐ **Level II** ☐ **Level III**

Hospital Name: _____
Mailing Address: _____
City, State, Zip: _____
County: _____ Trauma Service Area (TSA): _____

☐ **Initial Designation** ☐ **Re-Designation** **Expiration Date:** _____

Contact Person: _____
Title/position: _____
Phone Number(s): _____
Fax Number(s): _____
Email Address: _____

Number of licensed beds: _____ DSHS License Number: _____

Amount enclosed: $_____

Make check payable to: *"Texas Department of State Health Services"*

*(Fee for Level I/II): $10.00 per licensed bed – minimum fee $4,000 / maximum fee $5,000*

*(Fee for Level III): $10.00 per licensed bed –minimum fee $1,500/ maximum fee $2,500*

_____ _____
Typed name of CEO or authorized person Title

_____
Phone

_____ _____
Signature *(of CEO or authorized person)* Date

1. (This question applies to Level III applicants only): Indicate the full-time subspecialty services that are on-call to the emergency department: ☐ orthopaedics ☐ neurosurgery

2. Proposed date(s) for ACS survey (Month/Year): _____

3. Attach a current letter from the appropriate Regional Advisory Council stating that your facility is meeting RAC participation requirements.

4. Attach narratives describing:

   a) in detail the role of your facility in regional trauma system planning.

   b) the trauma-specific educational programs provided for your physicians, nurses, staff and pre-hospital personnel.

   c) the trauma program orientation process and annual credentialing for nurses throughout the continuum of care.

5. Does your hospital have a designated helipad? ☐ Yes ☐ No*
   * If "No" please attach a narrative describing location, access and protocols for establishing a landing zone.

6. Complete the emergency department nursing staff certifications:

| Total number of staff | |
|---|---|
| Percent with TNCC | % |
| Percent with PALS | % |
| Percent with ENPC | % |
| Percent with ACLS | % |
| Percent with CEN | % |

7. Complete the surgical/ trauma ICU nursing staff certifications:

| Total number of staff | |
|---|---|
| Percent with TNCC | % |
| Percent with PALS | % |
| Percent with ENPC | % |
| Percent with ACLS | % |
| Percent with CCRN | % |

8. What percent of patients entered in the trauma registry are complete within 45 days of discharge? _____%

**STEP B:** Two (2) copies of the completed ACS Pre-Review Questionnaire must be submitted to our office no later than 30 days prior to your scheduled ACS visit.