DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section

Application & Checklist for Hospital Trauma Center Designation

Instructions for Completing the Application & Checklist for Hospital Trauma Center Designation

1. Please fill out all information.
2. Please identify a designated contact person of the hospital for all information to be communicated through.
3. Please place all attachments behind this checklist in the order listed on the checklist.
4. Please submit the packet in its entirety with this checklist on top of all documents.

All packets will be reviewed by the administrative assistant. **If the packet is determined to be incomplete, the entire packet will be sent back to the facility for completion.** Once a packet is determined to be complete by the administrative assistant, it will be placed in line for processing. Please keep in mind that with the large volume of work being requested by hospitals, the wait time can be lengthy. The forms, fees and information should be submitted to the state office approximately **6 to 10 weeks prior to your anticipated opening date.**

The Department of Health and Hospitals shall not process any packet until all forms, required applicable accompanying information and fees are received.

Payment Information	
Check or Money Order Number:	
☐ Mail Payment & Payment Transmittal Form To	☐ Mail License Application Payment To
DHH Licensing Fee PO Box 62949 New Orleans, LA 70162-2949	Department of Health & Hospitals Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821-3767

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING•HEALTH STANDARDS SECTION
602 N. FIFTH STREET •SECOND FLOOR (70802) P.O. BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE #: (225) 342 • *0138* • FAX #: (225) 342-0157 www.dhh.louisiana.gov

Application & Checklist for Hospital Trauma Center Designation

Administrator:		**Designated Contact Person:**	
Administrator Phone:		**Designated Contact Phone:**	
Administrator Email:		**Designated Contact Email:**	
Hospital Name:			**Hospital License #:**
Hospital Address:			
Hospital Phone:		**Hospital Fax:**	

Letter of Intent

Are you applying to be designated as a licensed Trauma Center ☐ Yes ☐ No

Trauma Center Level you are applying for:

- **☐ Primary Level 1: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level I Trauma Centers**
- **☐ Primary Level II: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level II Trauma Centers**
- **☐Secondary Level III: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level III Trauma Centers**

Geographical location of the trauma center:

Name of the Building where the trauma center will be located:

Trauma Center Director:

Date of the American College of Surgeons approval as a Trauma Center:

Other Details:

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Criteria (Each of these must be attached in order for your application to be processed):	Yes	No	Describe
HSS-HO-34 Application & Checklist for Hospital Trauma Center Designation	☐		
Licensing Fee of $200.00 for the 3 year certification (please submit a copy of the transmittal form and copy of the check).	☐		Attach
Health Facility Plan Review Approval Letter from the Office of State Fire Marshal (OSFM) for the Health Standards Plan Review that is titled DHH FACILITY LICENSING RECOMMENDATION. The OSFM can NOT exempt this review. For information on this plan review, please visit our website at http://dhh.louisiana.gov/index.cfm/directory/detail/740.	☐		Attach
HSS-PR-02 Plan Review Attestation. Please ensure that the PO number matches the one on the DHH FACILITY LICENSING RECOMMENDATION letter.	☐		Attach
Site Map showing where the trauma center is located on the campus relative to other buildings, parking and streets. Please demarcate the trauma center area on the site plan.	☐		Attach
11 x 17 copies of the architecturally scaled floor plans for each floor of each building designated as the trauma center to include the green stamp of approval from the Office of state Marshal, dimensions, and identification of service areas (i.e. nurse's station, exam rooms, etc.). Please ensure that the number stamped on the floor plans by the Office of State Fire Marshal matches the number stamped on the DHH FACILITY LICENSING RECOMMENDATION letter. Please ensure that all areas of the floor plan can be read once printed. You can submit additional sheets for areas as long as the area is identified on the overall floor plan.	☐		Attach
Office of State Fire Marshall Inspection Report Approvals (Fire/Architectural/Sprinkler): Please submit the recent inspection reports for each building/area being licensed. The forms must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Office of Public Health Inspection Report Approval: Please submit the recent inspection reports for each building/area being licensed. The form must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Letter on hospital letterhead stating that either the hospital owns the space and it is not leased/subleased to anyone or that the hospital is the owner of the space through a lease/sublease.	☐		Attach
HSS-HO-09 Attestation Form	☐		Attach
Copy of the notification of Trauma Center verification by the American College of Surgeons, Committee on Trauma.	☐		Attach

Attestation & Signature

I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application in a separate packet. I attest that the Rural Health Clinic currently complies with the requirements of the Office of State Fire Marshal and Office of Public Health. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Authorized Representative's Printed Name & Title:

Authorized Representative's Signature	Date:

For DHH Use Only	Date	Yes	No	Comments
Incomplete Packet Sent Back To Facility along with an instructional letter:		☐	☐	
Packet ready for Program Manager Review		☐	☐	
Routed for licensing survey, Licensing Survey Completed & Approved		☐	☐	
ACO Updated (notes, buildings, cert kit application)		☐	☐	
CMS 1539s distributed		☐	☐	
POPS updated		☐	☐	
License & Letter distributed		☐	☐	
Logs Updated		☐	☐	
Prepped and submitted for filing		☐	☐	
Additional Comments:				

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