

**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.

<b>Payment Information</b>	
Check or Money Order Number:	
<input type="checkbox"/> Mail Payment & Payment Transmittal Form To	<input type="checkbox"/> 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

# Application & Checklist for Hospital Trauma Center Designation

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<b>Administrator:</b>		<b>Designated Contact Person:</b>	
<b>Administrator Phone:</b>		<b>Designated Contact Phone:</b>	
<b>Administrator Email:</b>		<b>Designated Contact Email:</b>	
<b>Hospital Name:</b>			<b>Hospital License #:</b>
<b>Hospital Address:</b>			
<b>Hospital Phone:</b>		<b>Hospital Fax:</b>	

**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 I: 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:**

<b>Criteria (Each of these must be attached in order for your application to be processed):</b>	Yes	No	Describe
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HSS-HO-034 (09/14)

# Application & Checklist for Hospital Trauma Center Designation

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HSS-HO-34 Application & Checklist for Hospital Trauma Center Designation	<input type="checkbox"/>		
Licensing Fee of \$200.00 for the 3 year certification (please submit a copy of the transmittal form and copy of the check).	<input type="checkbox"/>		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 <a href="http://dhh.louisiana.gov/index.cfm/directory/detail/740">http://dhh.louisiana.gov/index.cfm/directory/detail/740</a> .	<input type="checkbox"/>		Attach
HSS-PR-02 Plan Review Attestation. Please ensure that the PO number matches the one on the DHH FACILITY LICENSING RECOMMENDATION letter.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		Attach
HSS-HO-09 Attestation Form	<input type="checkbox"/>		Attach
Copy of the notification of Trauma Center verification by the American College of Surgeons, Committee on Trauma.	<input type="checkbox"/>		Attach
<b>Attestation &amp; Signature</b>			
<p>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.</p> <p>Authorized Representative's Printed Name &amp; Title:</p>			
Authorized Representative's Signature		Authorized Representative's Signature:	Date:
<b>For DHH Use Only</b>	Date	Yes	No
Incomplete Packet Sent Back To Facility along with an instructional letter:		<input type="checkbox"/>	<input type="checkbox"/>
Packet ready for Program Manager Review		<input type="checkbox"/>	<input type="checkbox"/>
Routed for licensing survey, Licensing Survey Completed & Approved		<input type="checkbox"/>	<input type="checkbox"/>
ACO Updated (notes, buildings, cert kit application)		<input type="checkbox"/>	<input type="checkbox"/>
CMS 1539s distributed		<input type="checkbox"/>	<input type="checkbox"/>
POPS updated		<input type="checkbox"/>	<input type="checkbox"/>
License & Letter distributed		<input type="checkbox"/>	<input type="checkbox"/>
Logs Updated		<input type="checkbox"/>	<input type="checkbox"/>
Prepped and submitted for filing		<input type="checkbox"/>	<input type="checkbox"/>
Additional Comments:			

HSS-HO-034 (09/14)



**Health Standards Section**

**Attestation for Compliance with  
Plan Review Directives**

<b>Plan Review Tracking Number:</b>	
<b>Project Being Attest To:</b>	
<b>Project Location Being Attested To:</b>	
<b>Purpose of the Plan Review Being Attested To:</b>	
<b>Hospital's License Number or DBA Name:</b>	
<b>Administrator:</b>	<b>Designated Contact Person:</b>
<b>Administrator Phone:</b>	<b>Designated Contact Person Phone#:</b>

This attestation form must be signed by the Administrator/Designee of the Facility. You must return this form as part of your DHH Licensing Application.

Attention: Read the Following Carefully Before Signing.

Statements of Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001).

I certify that I have reviewed the directives issued by the Plan Review Department relative to Plan Review Number P . Based upon my personal knowledge and belief, I attest that this facility has made all corrections (see next page) and met all directives on the letter issued for the date of . I attest that this facility meets and will continue to meet the applicable requirements set forth in the State of Louisiana Rules, Regulations and Minimum Standards, Standards of payment, all applicable Conditions of Participation/Conditions of Coverage found in the Code of Federal Regulations, and the current applicable Guidelines for Design and Construction of Health Care Facilities. I agree that if the facility fails to meet any of these requirements, I will notify the Health Standards Section of DHH of the changes immediately in order to permit a valid determination of the facility's compliance to the regulations. I understand that the Health Standards Section of DHH, Centers for Medicare and Medicaid Services (CMS), or its representatives, has the right to conduct an on-site survey at any time to validate whether the information provided is true.

Administrator/Designee Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Architect Signature (mandatory): \_\_\_\_\_ Date: \_\_\_\_\_



**Application & Checklist for Hospital  
Trauma Center Renewal**

**Instructions for Completing the Application & Checklist for Hospital  
Trauma Center Renewal**

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.

<b>Payment Information</b>	
Check or Money Order Number:	
<input type="checkbox"/> Mail Payment & Payment Transmittal Form To	<input type="checkbox"/> 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

# Application & Checklist for Hospital Trauma Center Renewal

Page 2

<b>Administrator:</b>		<b>Designated Contact Person:</b>	
<b>Administrator Phone:</b>		<b>Designated Contact Phone:</b>	
<b>Administrator Email:</b>		<b>Designated Contact Email:</b>	
<b>Hospital Name:</b>		<b>Hospital License #:</b>	
<b>Hospital Address:</b>			
<b>Hospital Phone:</b>		<b>Hospital Fax:</b>	
<b>Letter of Intent</b>			
<p>Are you applying to renew your designation as a Trauma Center <input type="checkbox"/> Yes <input type="checkbox"/> No (If this is for the initial licensing of a Trauma Center please use form HSS-HO-034)</p> <p>Trauma Center Level you are renewing:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> <b>Primary Level I: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level I Trauma Centers</b></li> <li><input type="checkbox"/> <b>Primary Level II: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level II Trauma Centers</b></li> <li><input type="checkbox"/> <b>Secondary Level III: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level III Trauma Centers</b></li> </ul> <p><b>Geographical location of the trauma center:</b></p> <p><b>Name of the Building where the trauma center is located:</b></p> <p><b>Trauma Center Director:</b></p> <p><b>Date of the American College of Surgeons most recent approval as a Trauma Center:</b></p> <p><b>Other Details:</b></p>			

# Application & Checklist for Hospital Trauma Center Renewal

Criteria (Each of these must be attached in order for your application to be processed):	Yes	No	Describe	
HSS-HO-34b Application & Checklist for Hospital Trauma Center Renewal	<input type="checkbox"/>			
Licensing Fee of \$200.00 for the 3 year certification (please submit a copy of the transmittal form and copy of the check).	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		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.	<input type="checkbox"/>		Attach	
HSS-HO-09 Attestation Form	<input type="checkbox"/>		Attach	
Copy of the notification letter of Trauma Center verification by the American College of Surgeons, Committee on Trauma and a copy of the certificate of verification.	<input type="checkbox"/>		Attach	
<b>Attestation &amp; Signature</b>				
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:	
Authorized Representative's Signature:			Date:	
<b>For DHH Use Only</b>	Date	Yes	No	Comments
Incomplete Packet Sent Back To Facility along with an instructional letter:		<input type="checkbox"/>	<input type="checkbox"/>	
Packet ready for Program Manager Review		<input type="checkbox"/>	<input type="checkbox"/>	
Routed for licensing survey, Licensing Survey Completed & Approved		<input type="checkbox"/>	<input type="checkbox"/>	
ACO Updated (notes, buildings, cert kit application)		<input type="checkbox"/>	<input type="checkbox"/>	
CMS 1539s distributed		<input type="checkbox"/>	<input type="checkbox"/>	
POPS updated		<input type="checkbox"/>	<input type="checkbox"/>	
License & Letter distributed		<input type="checkbox"/>	<input type="checkbox"/>	
Logs Updated		<input type="checkbox"/>	<input type="checkbox"/>	
Prepped and submitted for filing		<input type="checkbox"/>	<input type="checkbox"/>	
Additional Comments:				



**Attestation for a Licensed &  
Certified Hospital**

**Instructions for Completing the Attestation Form**

**We have recently revised the format of the Attestation form. Please review these instructions before filling out the Attestation Form.**

1. List the date of the license application this form is associated with.
2. List the effective date of the attestation.
3. List the hospital's DBA name as it appears on the license.
4. List the geographical address of the hospital.
5. List the telephone number (direct line, no voice mail) and fax number of the hospital.
6. List the name of the location being attested to. Example ABC Hospital – EFJ Off-Site Campus (Medical Surgical 4<sup>th</sup> floor, rooms 401, 402, 403, & 404)
7. List the address of the location being attested to.
8. List the phone number of the area being attested to.
9. Document the purpose of the areas of the attestation.
10. Please review all State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 93) governing hospitals to ensure the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.
11. Please review all applicable Conditions of Participation found in the current Code of Federal Regulations to ensure the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.
12. Please review the current version of the American Institute of Architects Guidelines for Design & Construction of Health Care Facilities to ensure that the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.
13. All decisions regarding the acceptance of attestations in lieu of on-site surveys are made on a case-by-case basis.



**Health Standards Section**

**Attestation for a Licensed & Certified Hospital**

<b>Application Date:</b>	<b>Effective Date:</b>
<b>Administrator:</b>	<b>Designated Contact Person:</b>
<b>Hospital Name:</b>	
<b>Hospital Address:</b>	
<b>Hospital Phone:</b>	<b>Hospital Fax:</b>
<b>Name of Location Being Attested To:</b>	
<b>Address of Location Being Attested To:</b>	
<b>Phone Number of Location Being Attested To:</b>	
<b>Purpose of Location Being Attested To:</b>	

This attestation form must be signed by the Administrator/Designee of the Hospital and each page of the Attestation Form must be initialed and dated.

Attention: Read the Following Carefully Before Signing.

Statements or Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001)

I certify that I have reviewed the hospital licensing requirements and based upon my personal knowledge and belief, I attest that \_\_\_\_\_ (hospital location being attested to), effective (requested effective date), meets and will continue to meet the applicable requirements for hospitals set forth in the State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 93) governing Hospitals, all applicable Conditions of Participation found in the Code of Federal Regulations for hospital, and the current applicable guidelines found in the American Institute of Architects Guidelines for Design & Construction of Health Care Facilities. I agree that if the hospital fails to meet any of these requirements, I will notify the Health Standards Section of DHH of the changes immediately in order to permit a valid determination of the hospitals' compliance to the regulations. I understand that the Health Standards Section of DHH, Centers for Medicare and Medicaid Services (CMS), or its representative, has the right to conduct an on-site survey at any time to validate whether the information provided is true.

Signature: \_\_\_\_\_ (Administrator/Designee) \_\_\_\_\_ (mo/dd/yr)