FCC Form **465**

Health Care Providers Universal Service
Description of Services Requested & Certification Form

Approval by OMB 3060—0804

Estimated time per response: 1 hour

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Form 465 Application Number (assigned by RHCD)

Information required in this block applies to the **physical location** of the HCP. Do not enter a "PO Box" or "Rural Route" address.

1 HCP Number	17257		2 Consortium Name	St. Joseph's Hospital	
3 HCP Name	St. Joseph's Hospital		4 HCP FCC Registration Number (FCC RN)	0017410317	
5 Contact Name	Joan Coffman				
6 Address Line 1	2661 County Highway I				
7 Address Line 2			8 County	Chippewa	
9 City	Chippewa Falls		10 State WI	11 ZIP Code	54729
12 Phone #	715-717-7200	13 Fax #	715-717-7204	14 E-mail	jcoffman@sjcf.hshs.org

15 Is the HCP's mailing address (where correspondence should be sent) different from its physical location described in Block 1?
- [x] Yes, complete Block 2
- [ ] No, go to Block 3.

16 Contact Name	Kevin Groskreutz		17 Organization	St. Joseph's Hospital	
18 Address Line 1	2661 County Hwy I				
19 Address Line 2					
20 City	Chippewa Falls		21 State WI	22 ZIP Code	54729
23 Phone #	715 717 5030	24 Fax #	715-717-1671	25 E-mail	kgroskreutz@sjcf.hshs.org

26 Funding Year (Check only one box)
- [ ] Year 2007 (7/1/2007-6/30/2008)
- [ ] Year 2008 (7/1/2008-6/30/2009)
- [X] Year 2009 (7/1/2009-6/30/2010)

27 Only the following types of HCPs are eligible. Indicate which category describes the applicant. (Check only one.)
- [ ] Post-secondary educational institution offering health care instruction, teaching hospital or medical school
- [ ] Community health center or health center providing health care to migrants
- [ ] Local health department or agency
- [ ] Community mental health center
- [ ] Not-for-profit hospital
- [ ] Rural health clinic
- [x] Consortium of the above
- [ ] Dedicated ER of rural, for-profit hospital
- [ ] Part-time eligible entity

28 If consortium, dedicated emergency department, or part-time eligible entity was selected in Line 27, please describe the entity.
A group consisting of urban and rural hospitals.

29 Please describe the eligible health care provider's telecommunications and/or Internet service needs, so that service providers may bid to provide the services. The description should describe whether video or store and forward consultations will be used, whether large image files or X-rays will be transmitted, the quality of connection needed, or other relevant considerations.
This is a FY Rural Healthcare Pilot Program bridge funding application. St. Joseph's Hospital is seeking service substitution support to upgrade existing T-1 services to fiber services. Please see scoping document/RFP for details

30 Is the HCP requesting reduced rates for:
- [x] Both Telecommunications & Internet Services
- [ ] Telecommunications Service ONLY
- [ ] Internet Service ONLY

31 [x] I certify that I am authorized to submit this request on behalf of the above-named entity or entities, that I have examined this request, and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
32 [x] I certify that the health care provider has followed any applicable State or local procurement rules.	
33 [x] I certify that the telecommunications services that the HCP receives at reduced rates as a result of the HCP's participation in this program, pursuant to 47 U.S.C. Sec. 254 as implemented by the Federal Communications Commission, will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.	
34 [x] I certify that the health care provider is a non-profit or public entity.	
35 [x] I certify that the health care provider is located in a rural area. Visit the RHCD website: (www.rhc.universalservice.org/eligibility/ruralareas.asp) or contact RHCD at 1-800-229-5476 for a listing of rural areas.	
36 [x] Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to funding provided under 47 U.S.C. Sec. 254.	
37 Signature	38 Date 9/12/2012
39 Printed name of authorized person Joan Goffman	40 Title or position of authorized person CEO
41 Employer of authorized person St. Joseph's Hospital	42 Employer's FCC RN 0017410317

Please remember:

- Form 465 is the **first** step a health care provider must take in order to receive the benefit of reduced rates resulting from participation in this universal service support program.
- After the HCP submits a complete and accurate Form 465, the RHCD will post it on the RHCD web site for 28 days.
- HCPs may not enter into agreements to purchase eligible services from service providers before the **28 days expire**.
- After the HCP selects a service provider, the HCP must initiate the **next** step in the application process, the filing of Form 466 and/or 466A.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to jboley@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:

Rural Health Care Division
30 Lanidex Plaza West
PO Box 685