

**Health Care Providers Universal Service  
Internet Service Funding Request and Certification Form**  
(And Advanced Services Funding Request and Certification for Entirely Rural States)

The Deadline to submit this Form is the June 30th End of the Funding Year. Estimated time per response: 1 hour

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

<b>Block 1: HCP Information</b>			
1 HCP Name		2 HCP Number	
3 Form 465 Application #		4 Consortium Name (If any)	
<b>Block 2: Bill Payer Information</b>			
5 Billed Entity Name		6 Billed Entity's FCC RN	
7 Contact Name			
8 Address Line 1			
9 Address Line 2			
10 City		11 State	12 Zip
13 Contact Phone #		14 Fax #	15 E-Mail
<b>Block 3: Funding Year Information</b>			
16 Funding Year - Check only one box			
<input type="checkbox"/> Year 2010 (7/1/2010-6/30/2011)		<input checked="" type="checkbox"/> Year 2011 (7/1/2011-6/30/2012)	<input type="checkbox"/> Year 2012 (7/1/2012-6/30/2013)
<b>Block 4: Service Information</b>			
17 Give a brief description of the service for which support is requested:			
18 Percentage of HCP's service used for the provision of health care. (If less than 100%, please explain.)			
19 Location where service is provided:			
20 Service Provider Name			
21 Service Provider Identification Number (SPIN)		22 Billing Account Number	
23 Contract Number (NA if no contract)		24 Date contract signed or service selected	
25 Contract Expiration Date (NA if no contract)		26 Expected Service Start Date	
27 Were bids received in response to Form 465? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, submit copies.			
<b>Block 5: Cost of Service</b>			
28 Installation Charge (If applicable)		29 Monthly rate charge (Enclose documentation)	
<b>Block 6: Certification</b>			
30 <input type="checkbox"/> I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.			
31 <input type="checkbox"/> 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 universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.			
32 <input type="checkbox"/> I hereby certify that the billed entity requesting reduced rates will maintain complete records for the service for five years.			
33 <input type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.			
34 Signature		35 Date	
36 Printed name of authorized person		37 Title or position of authorized person	
38 Employer of authorized person		39 Employer's FCC RN	

**Please remember:**

- ◆ An applicant may not file a Form 466-A until after signing the contract or otherwise selecting a service provider
- ◆ **The HCP or its authorized representative must wait at least 28 days from the Form 465 posting date before signing the contract or otherwise selecting a service provider.**
- ◆ You must be authorized to provide the information required by Form 466-A on behalf of the HCP, and you must sign and date the form.
- ◆ **Provide data for all items that apply. Attach additional sheets if necessary. Any attachments to Form 466-A must be clearly labeled.**

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 data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). 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 pra@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 PAPERWORK 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, P.O.Box 685  
Parsippany NJ 07054-0685