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)

## Block 1: HCP Location Information

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 | 2 Consortium Name | |
| 3 HCP Name | 4 HCP FCC Registration Number (FCC RN) | |
| 5 Contact Name | | |
| 6 Address Line 1 | | |
| 7 Address Line 2 | 8 County | |
| 9 City | 10 State | 11 ZIP Code |
| 12 Phone # | 13 Fax # | 14 E-mail |

## Block 2: HCP Mailing Contact Information

15 Is the HCP's mailing address (where correspondence should be sent) different from its physical location described in Block 1?

- ☐ Yes, complete Block 2
- ☐ No, go to Block 3.

| | | |
|---|---|---|
| 16 Contact Name | 17 Organization | |
| 18 Address Line 1 | | |
| 19 Address Line 2 | | |
| 20 City | 21 State | 22 ZIP Code |
| 23 Phone # | 24 Fax # | 25 E-mail |

## Block 3: Funding Year Information

26 Funding Year (Check only one box)

☐ Year 2019 (07/01/2019 - 06/30/2020) ☐ Year 2020 (07/01/2020 - 06/30/2021) ☐ Year 2021 (07/01/2021 - 06/30/2022)

## Block 4: Eligibility

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
- ☐ Skilled nursing facility
- ☐ 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.

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.

## Block 5: Request for Services

30 The HCP is requesting reduced rates for:

- ☐ Telecommunications Service

## Block 6: Certification

| | |
|---|---|
| 31 ☐ | I certify that I am authorized to submit this request on behalf of the above-named health care provider (HCP), 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 ☐ | I certify that the health care provider (HCP) has followed any applicable State or local procurement rules. |
| 33 ☐ | 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. § 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 ☐ | I certify that the health care provider (HCP) is a non-profit or public entity. |
| 35 ☐ | I certify that the health care provider (HCP) is located in a rural area. Visit the Eligible Rural Areas Search Tool on the Telecommunications Program web page at http://usac.org/rhc/telecommunications/tools/rural/search/search.asp or contact RHC at (800) 453-1546 for a listing of rural areas. |
| 36 ☐ | Pursuant to 47 C.F.R. § 54.601 and 54.603, I certify that the health care provider (HCP) 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. § 254. |

| | |
|---|---|
| 37 Signature | 38 Date |
| 39 Printed name of authorized person | 40 Title or position of authorized person |
| 41 Employer of authorized person | 42 Employer's FCC RN |

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, 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.

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 REQUIRED BY THE PAPERWORK REDUCTION ACT

Part 54 of the Federal Communications Commission's (FCC) rules authorize the FCC to collect the information requested in this form. Responses to the questions herein are required to obtain the benefits sought by this form. Failure to provide all requested information will delay processing or result in the form being returned without action. Information requested by this form will be available for public inspection. The information provided will be used to determine whether approving this request is in the public interest.

We have estimated that each response to this collection of information will take 1 hour. Our estimate includes the time to read the instructions, look through existing records, gather and maintain the required data, and actually complete and review the form or response. If you have any comments on this estimate, or on how we can improve the collection and reduce the burden it causes you, please write the Federal Communications Commission, AMD-PERM, Paperwork Reduction Project (3060-0804), Washington, DC 20554. We will also accept your comments via the Internet if you send them to pra@fcc.gov. Please DO NOT SEND COMPLETED APPICATIONS 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 PAPEWORK REDUCTION ACT OF 1995, P.L.104-13, OCTOBER 1, 1995, 44 U.S.C.§ 3507.**

This form should be submitted online through the RHC Program online application system, My Portal.
https://forms.universalservice.org/usaclogin/login.asp

## Block 1: HCP Location Information (continued)

Legal Entity Name:

Contact Employer:

Title:

## Block 4: Eligibility (continued)

Provide a brief explanation of why this site qualifies as the organization type selected.

Tribal affiliation:

- ☐ On Tribal Lands
- ☐ Operated by the Indian Health Service
- ☐ Otherwise Affiliated with a Tribe
- ☐ N/A

## Additional Information

Employer Identification Number (EIN):

National Provider Identifier (NPI):

Explanation if no NPI:

Organization Taxonomy Code:

Site Taxonomy Code:

Explanation if no Site Taxonomy Code:

**Block 5: Request for Services (continued)**

Requested Contract Period:

Number of Days USAC Should Post:

Posting End Date:

Expected Bid Evaluation Period (Days):

Identify Anticipated Application(s) and Use(s) of the Supported Connection

| Capability | Usage Level | Usage Period |
|---|---|---|

Category: Interactive

- ☐ Distance learning/training
- ☐ Real-time remote examination, consultation, and/or monitoring
- ☐ Video conferencing
- ☐ Voice service
- ☐ Other (describe):

Category: Transactional

- ☐ Distance learning/training
- ☐ Electronic patient billing
- ☐ Exchange of electronic health records
- ☐ Transmission of large files (e.g., X-ray images, MRI, etc)
- ☐ Other (describe):

Category: Bulk

- ☐ Electronic patient billing
- ☐ Exchange of electronic health records
- ☐ Transmission of large files (e.g., X-ray images, MRI, etc)
- ☐ Transmission of store and forward consultations
- ☐ Other (describe):

Category: Miscellaneous

- ☐ Backup/redundant connectivity
- ☐ Other (describe):

## Bid Evaluation

Select criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services.

| Criteria | Description (if 'Other') | Weight (%) |
|---|---|---|
| | | |

## Declaration of Assistance

Contact 1

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Contact 2

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

**Declaration of Assistance (continued)**

Contact 3

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Contact 4

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Contact 5

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code: