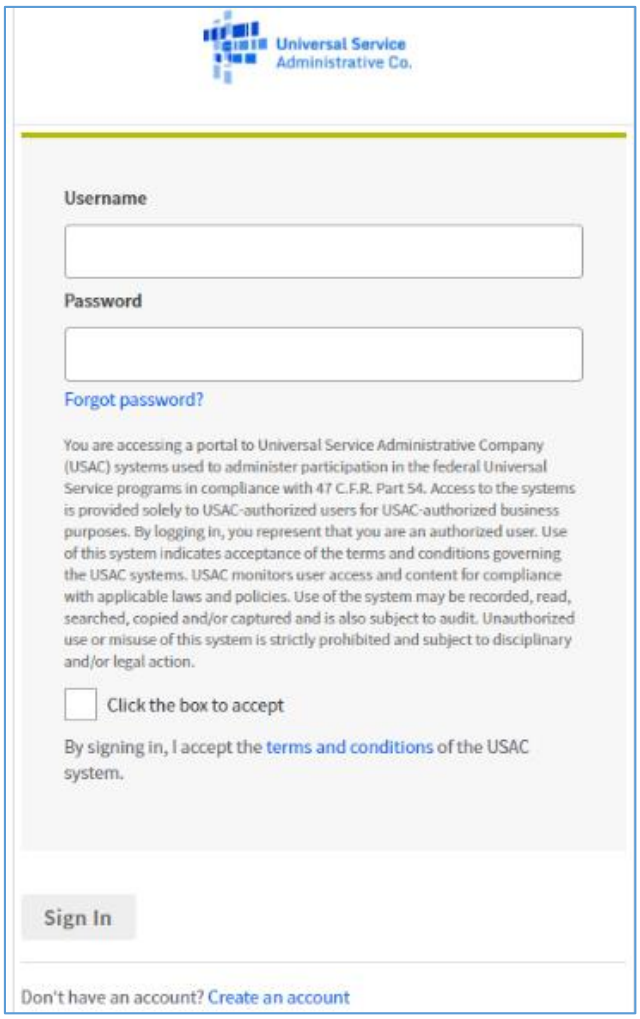
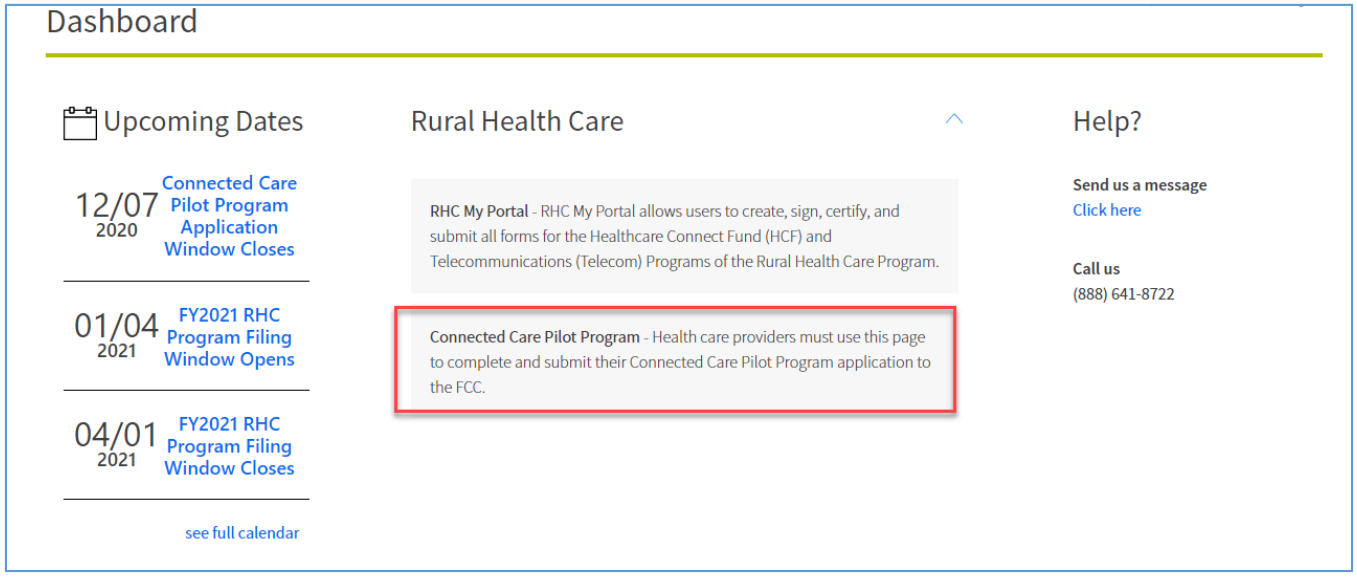
Connected Care Pilot Program

Application View

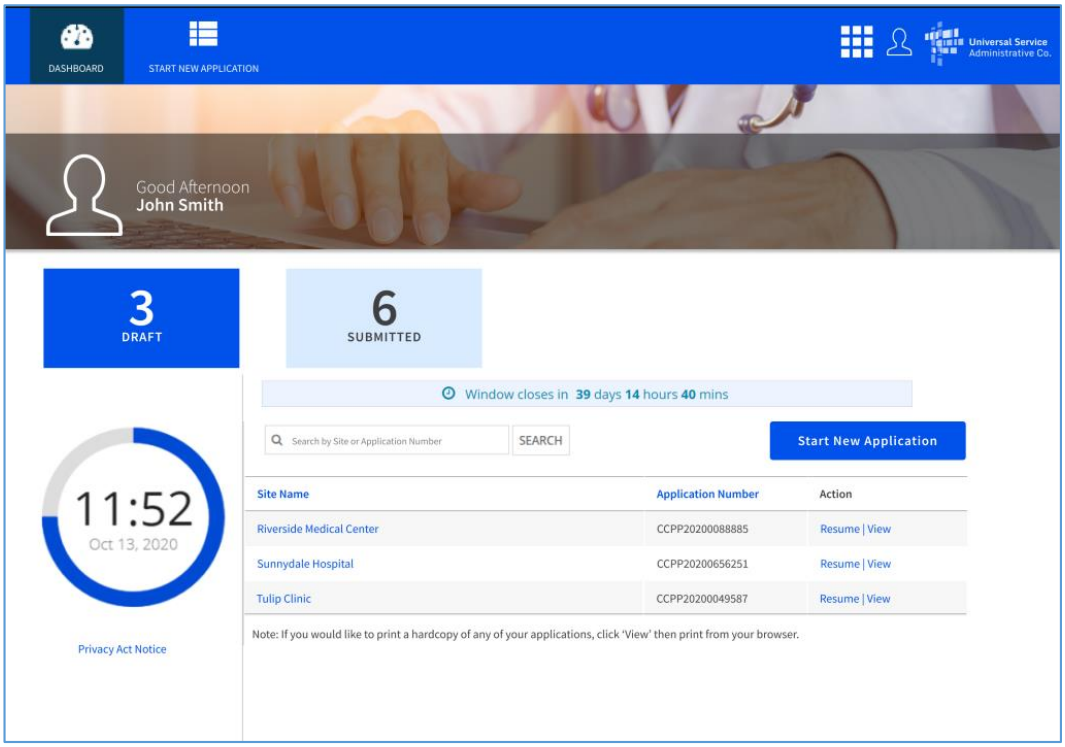
Log in to My Portal – Go to My Portal. Your Username is your email address. Instructions to set up your My Portal account are included in your FCC Form 460 Approval email.



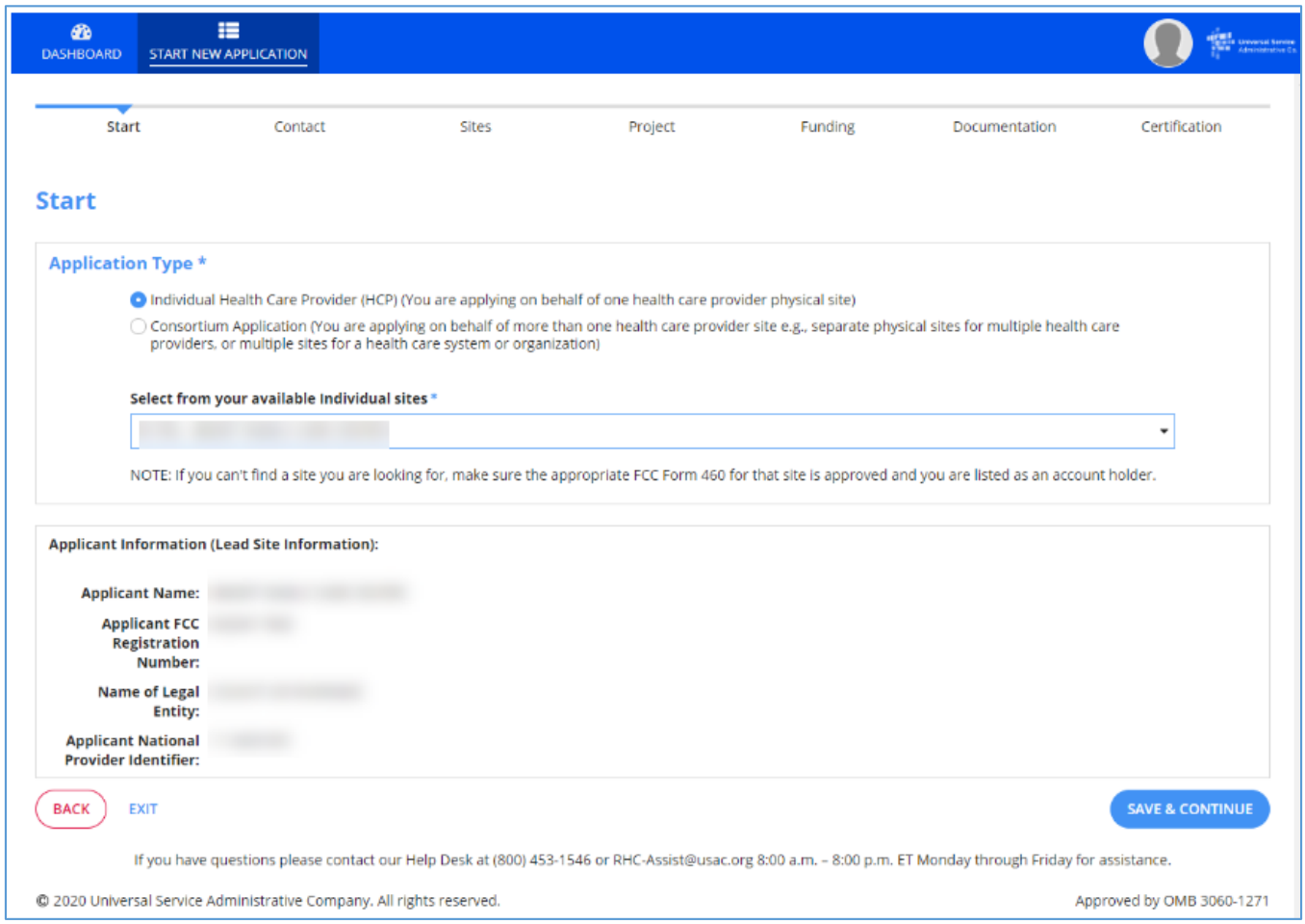
Select Connected Care Pilot Program – From the dashboard homepage select Connected Care Pilot Program.



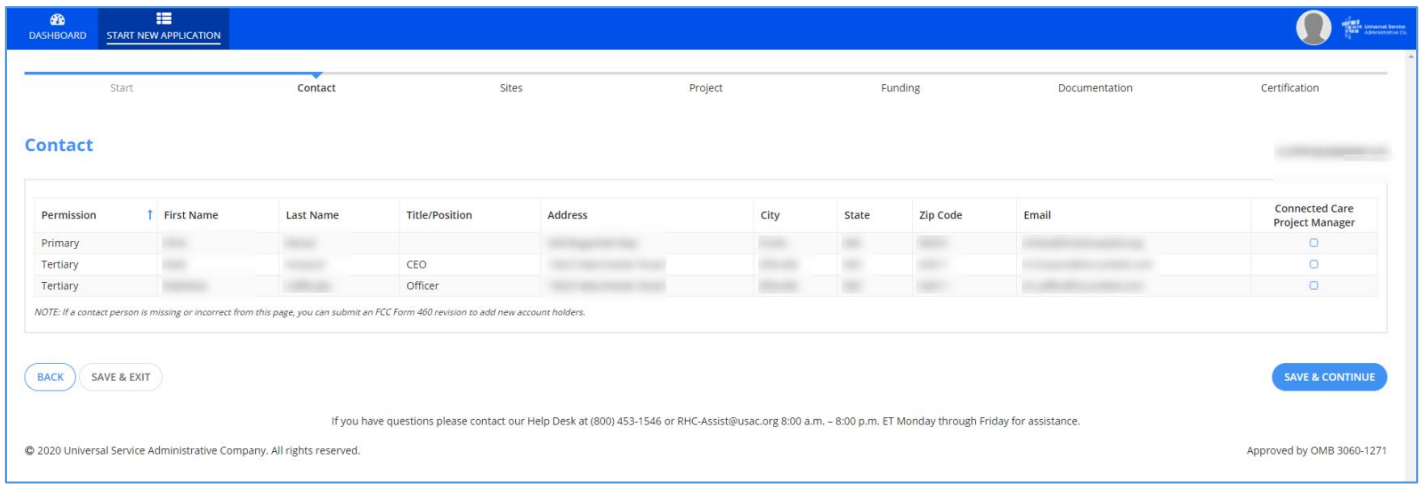
Dashboard View



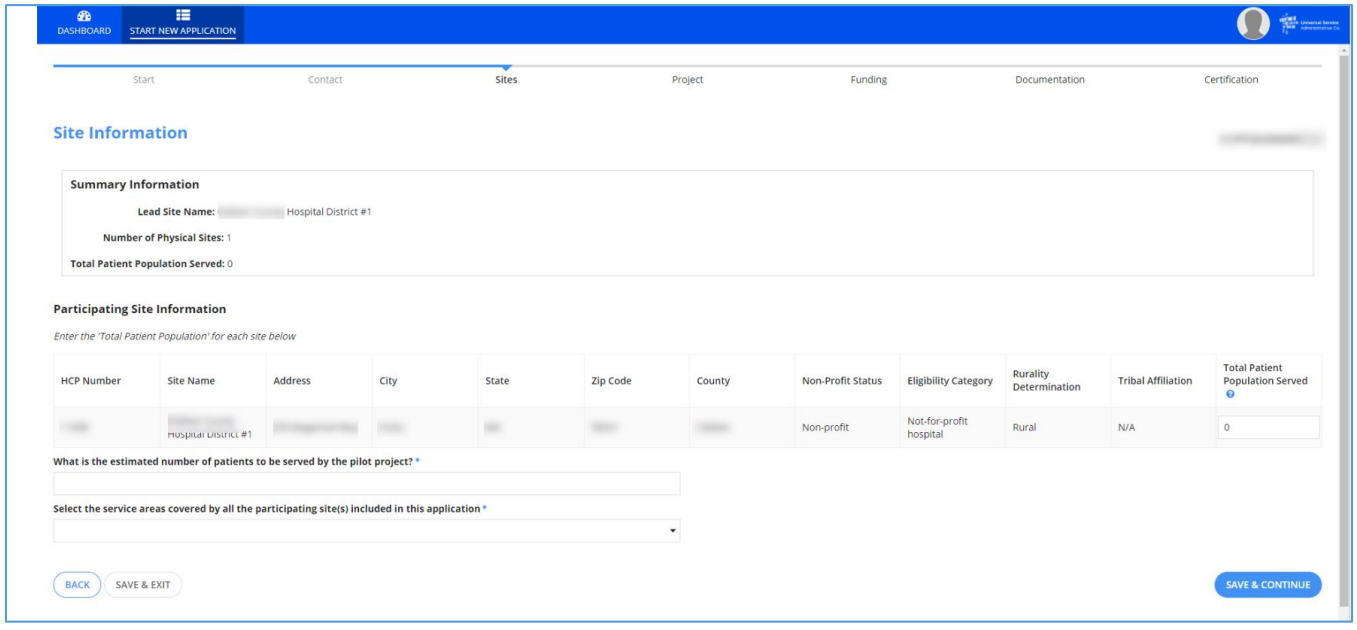
Application Type



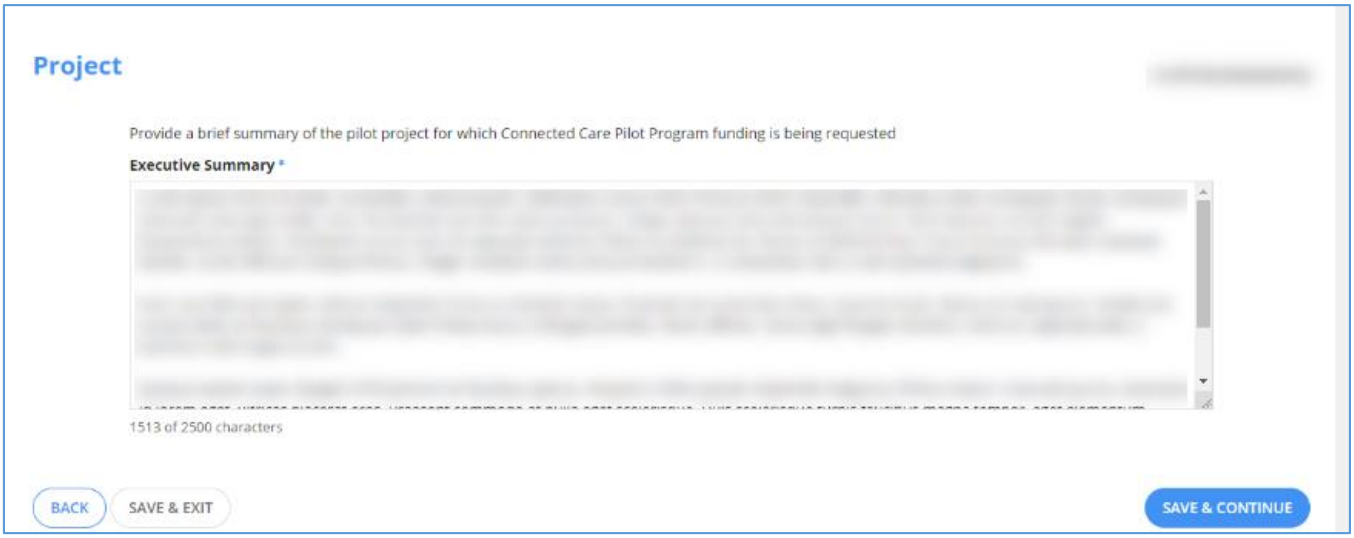
Contact

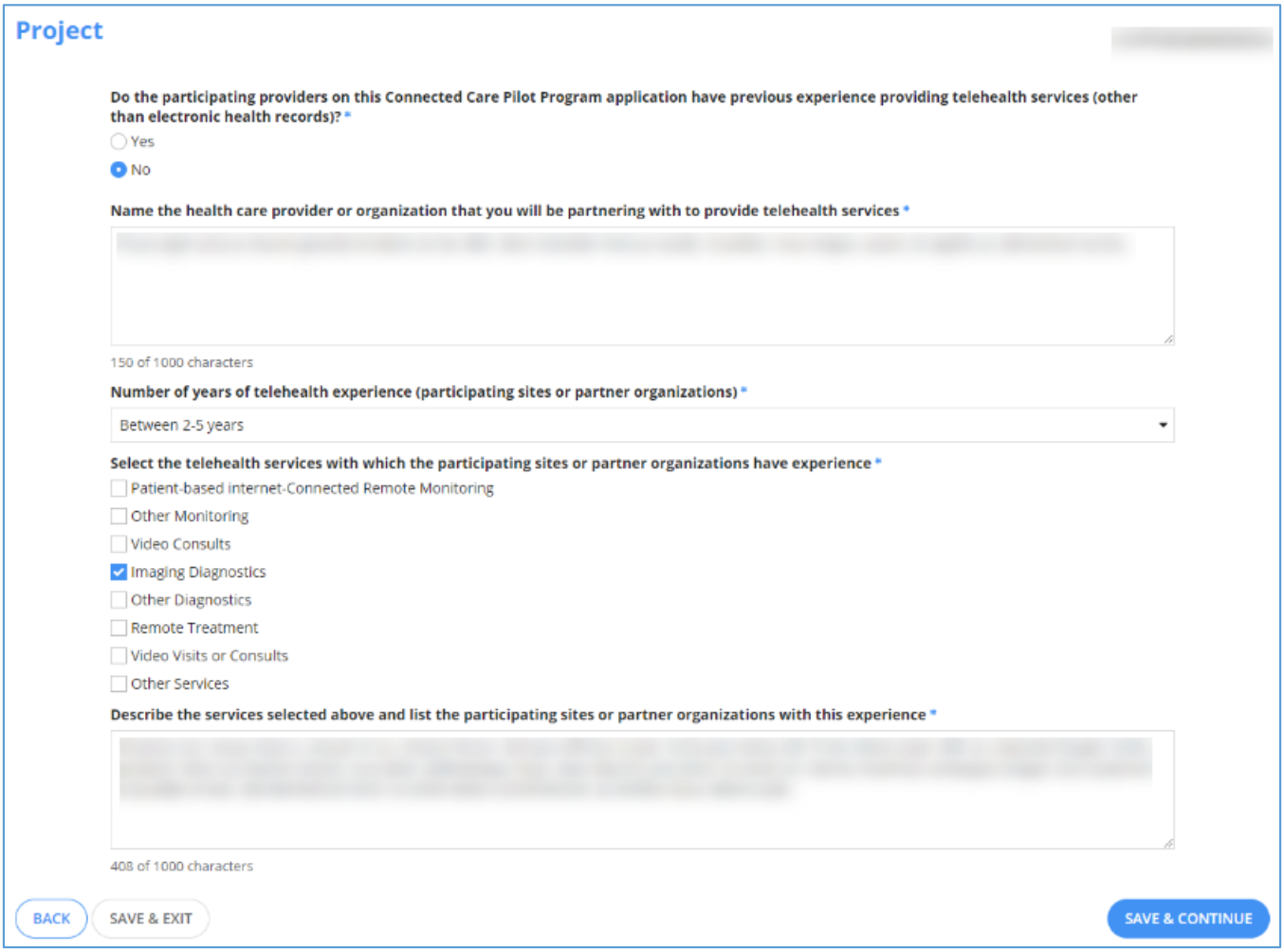


Site Information



Project


Project
Provide a brief summary of the pilot project for which Connected Care Pilot Program funding is being requested
Executive Summary *
1513 of 2500 characters
BACK
SAVE & EXIT
SAVE & CONTINUE


Project
Do the participating providers on this Connected Care Pilot Program application have previous experience providing telehealth services (other than electronic health records)? *
Yes
No
Name the health care provider or organization that you will be partnering with to provide telehealth services *
150 of 1000 characters
Number of years of telehealth experience (participating sites or partner organizations) *
Between 2-5 years
Select the telehealth services with which the participating sites or partner organizations have experience *
Patient-based internet-Connected Remote Monitoring
Other Monitoring
Video Consults
Imaging Diagnostics
Other Diagnostics
Remote Treatment
Video Visits or Consults
Other Services
Describe the services selected above and list the participating sites or partner organizations with this experience *
408 of 1000 characters
BACK
SAVE & EXIT
SAVE & CONTINUE

Project

Select the geographic areas and populations served by the participating providers on this Connected Care Pilot Program application *

- [ ] A geographic area with a large underserved or low-income population. (For purposes of the Pilot Program, health care providers can determine whether a patient is considered low-income by determining whether (1) the patient is eligible for Medicaid or (2) the patient's household income is at or below 135% of the U.S. Department of Health and Human Services Federal Poverty Guidelines (FCC 20-44, para. 52))
- [ ] A geographic area that has experienced recent health care provider closures or other health care shortages or deficiencies
- [x] A geographic area that is subject to other factors that affect the ability of the population to obtain or access health care services
- [ ] N/A

Please describe *

328 of 2500 characters

BACK | SAVE & EXIT | SAVE & CONTINUE

The proposed pilot project will serve (check all that apply)

- [ ] Department of Health and Human Services, Health Resources & Services Administration (HRSA) designated Health Professional Shortage Areas for primary care or mental health care only). Refer to the HRSA HPSA look-up tool at: https://data.hrsa.gov/tools/shortage-area/hpsa-find
- [x] Medically Underserved Areas as defined by the HRSA. Refer to the HRSA MUA look-up tool at: https://data.hrsa.gov/tools/shortage-area/mua-find

Please identify these areas: *

2 of 1000 characters

- [ ] N/A

Would the participating providers that are included in this application and located in non-rural areas primarily serve veterans and low-income patients in rural areas? If so, list the counties where patients will be served. *

- (•) Yes
- ( ) No

Enter the percentage of the total patient population that falls into this category *

Please explain and identify the rural counties *

2 of 1000 characters

Would the pilot project primarily serve veterans or low-income patients? *

- ○ Veterans
- ○ Low-Income
- ◉ Both
- ○ Neither

Enter the estimated percentage of the total patient population served by the pilot project that are veterans *

Enter the estimated percentage of the total patient population served by the pilot project that are low-income *

Please explain *

136 of 1000 characters

Are the participating providers on this Connected Care Pilot Program application affiliated or partnered with Veterans Affairs facilities? *

- ◉ Yes
- ○ No

Please explain: *

374 of 1000 characters

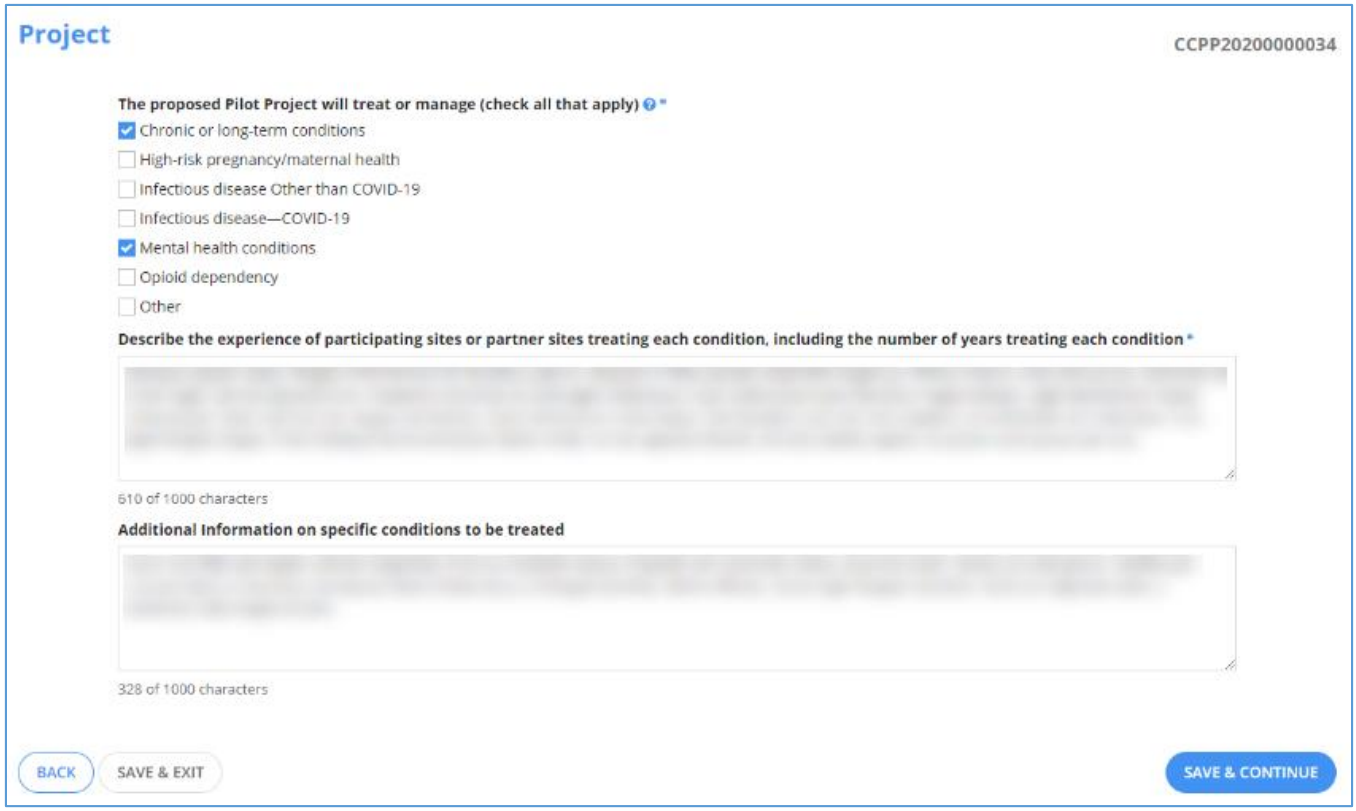
BACK | SAVE & EXIT | SAVE & CONTINUE

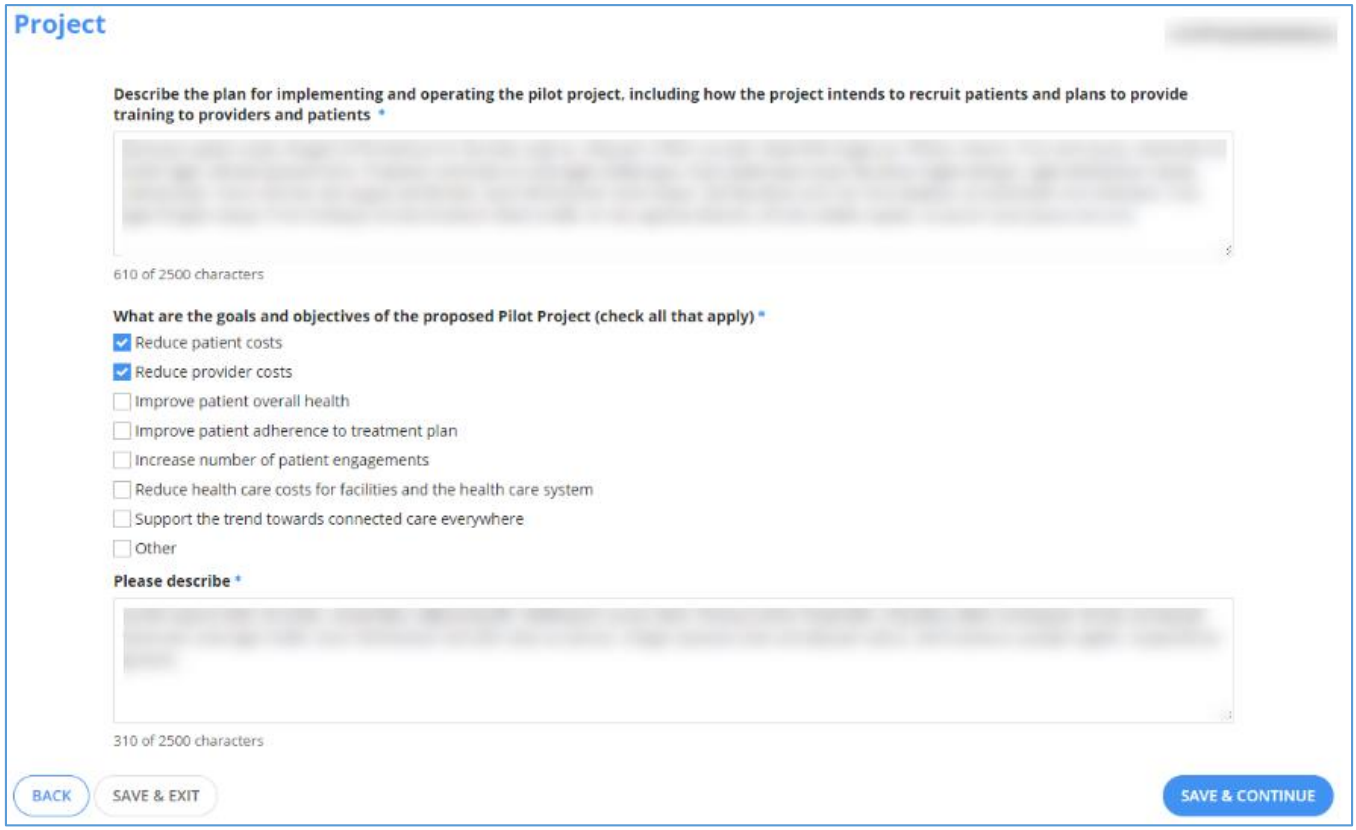
Have any of the health care provider sites for the proposed pilot project received or expect to receive funding from any FCC program (Telecommunications Program, Healthcare Connect Fund Program, COVID-19 Telehealth Program, etc.)? *

- ◉ Yes
- ○ No

Please provide the relevant application number(s) or Funding Request Numbers and describe what the program funding was or is or will be used for and how your Pilot Program funding request differs *

0 of 1000 characters


Project
CCPP20200000034
The proposed Pilot Project will treat or manage (check all that apply) *
Chronic or long-term conditions
High-risk pregnancy/maternal health
Infectious disease Other than COVID-19
Infectious disease—COVID-19
Mental health conditions
Opioid dependency
Other
Describe the experience of participating sites or partner sites treating each condition, including the number of years treating each condition *
610 of 1000 characters
Additional Information on specific conditions to be treated
328 of 1000 characters
BACK
SAVE & EXIT
SAVE & CONTINUE


Project
Describe the plan for implementing and operating the pilot project, including how the project intends to recruit patients and plans to provide training to providers and patients *
610 of 2500 characters
What are the goals and objectives of the proposed Pilot Project (check all that apply) *
Reduce patient costs
Reduce provider costs
Improve patient overall health
Improve patient adherence to treatment plan
Increase number of patient engagements
Reduce health care costs for facilities and the health care system
Support the trend towards connected care everywhere
Other
Please describe *
310 of 2500 characters
BACK
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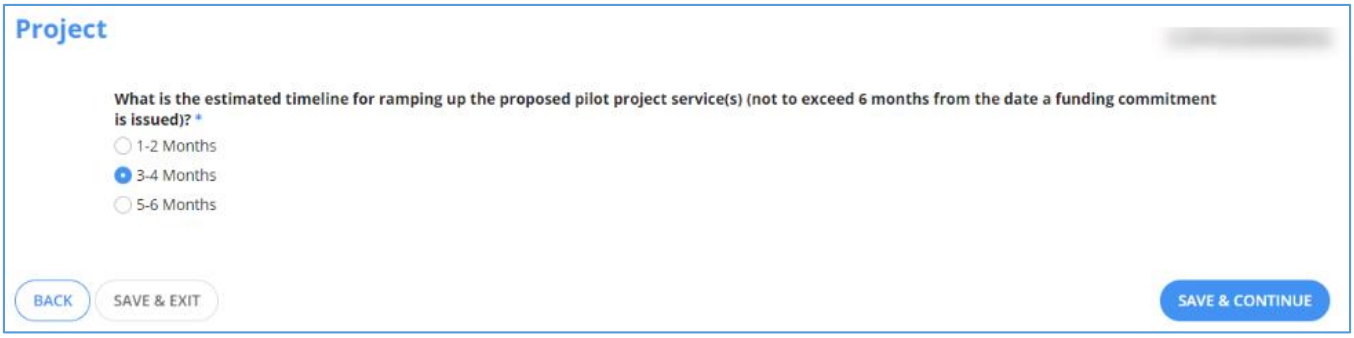
SAVE & CONTINUE


Project
What is the estimated timeline for ramping up the proposed pilot project service(s) (not to exceed 6 months from the date a funding commitment is issued)? *
1-2 Months
3-4 Months
5-6 Months
BACK
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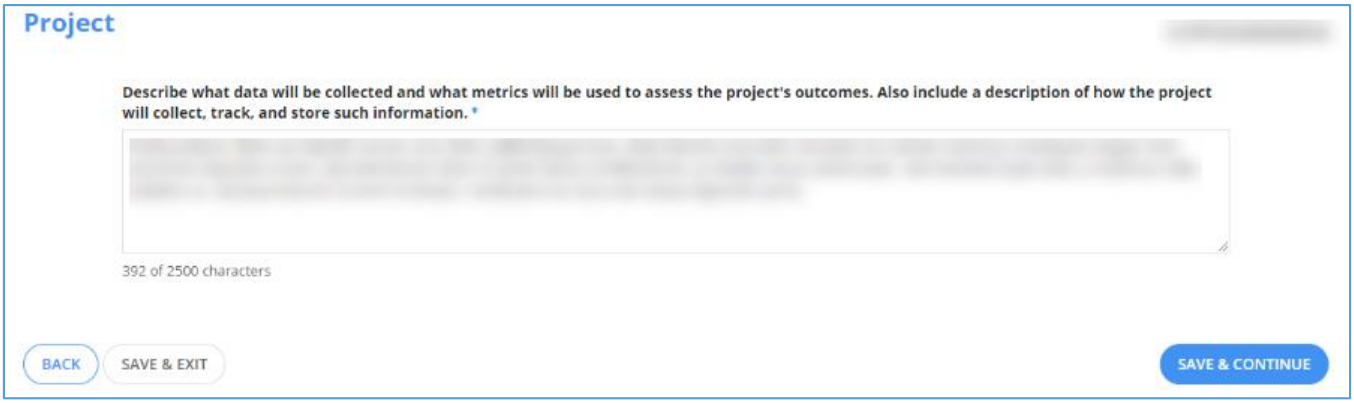
Project
Describe what data will be collected and what metrics will be used to assess the project's outcomes. Also include a description of how the project will collect, track, and store such information. *
392 of 2500 characters
BACK
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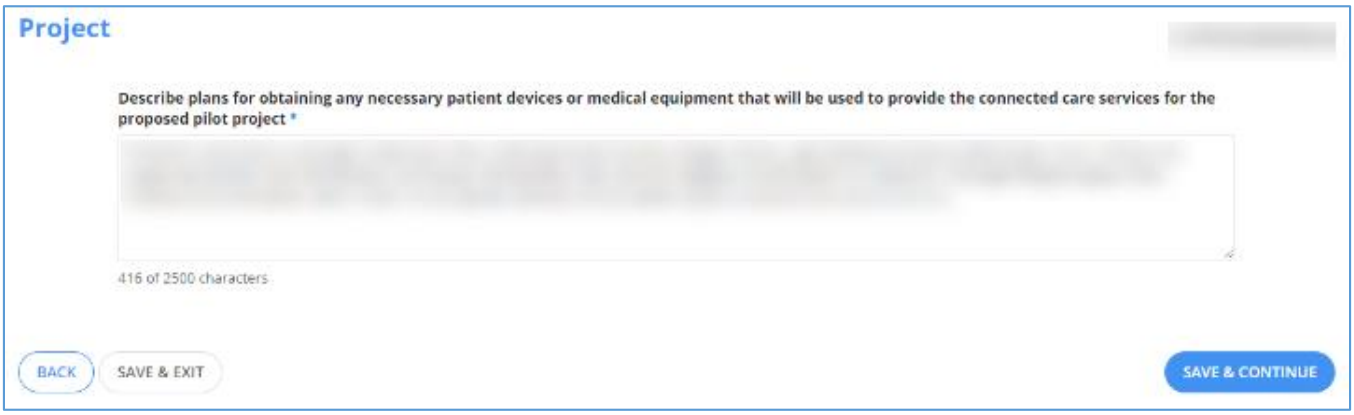
SAVE & CONTINUE


Project
Describe plans for obtaining any necessary patient devices or medical equipment that will be used to provide the connected care services for the proposed pilot project *
416 of 2500 characters
BACK
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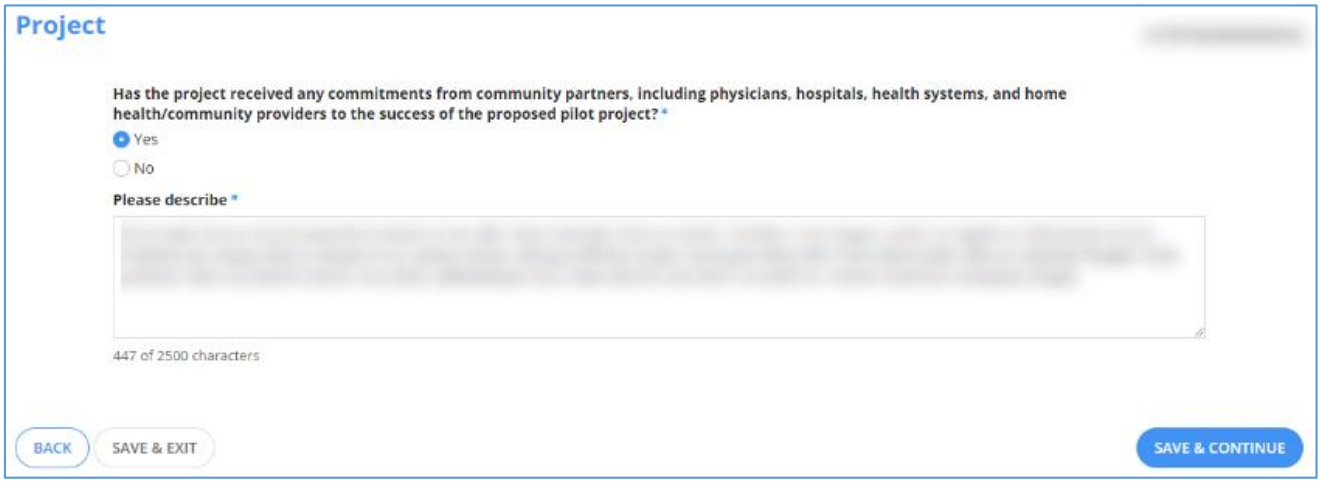
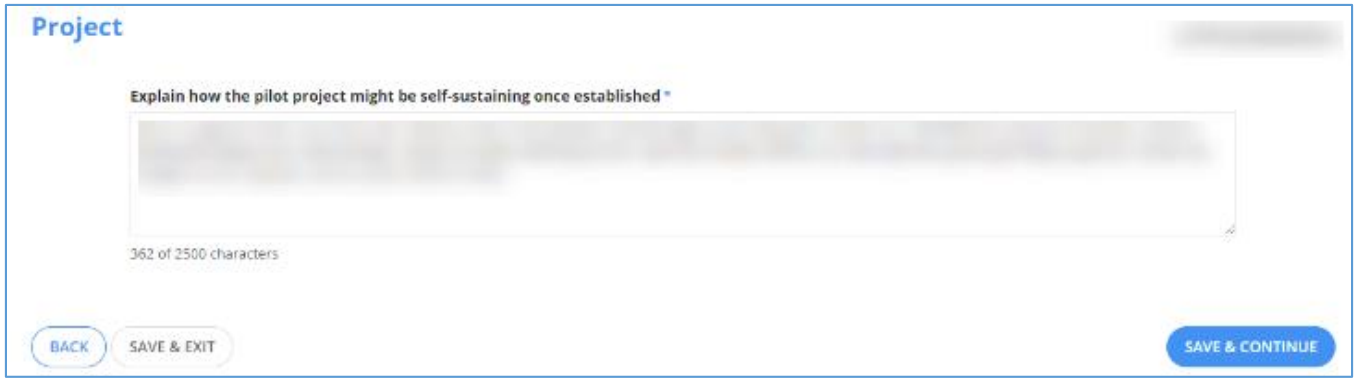
SAVE & CONTINUE


Project
Has the project received any commitments from community partners, including physicians, hospitals, health systems, and home health/community providers to the success of the proposed pilot project? *
Yes
No
Please describe *
447 of 2500 characters
BACK
SAVE & EXIT
SAVE & CONTINUE

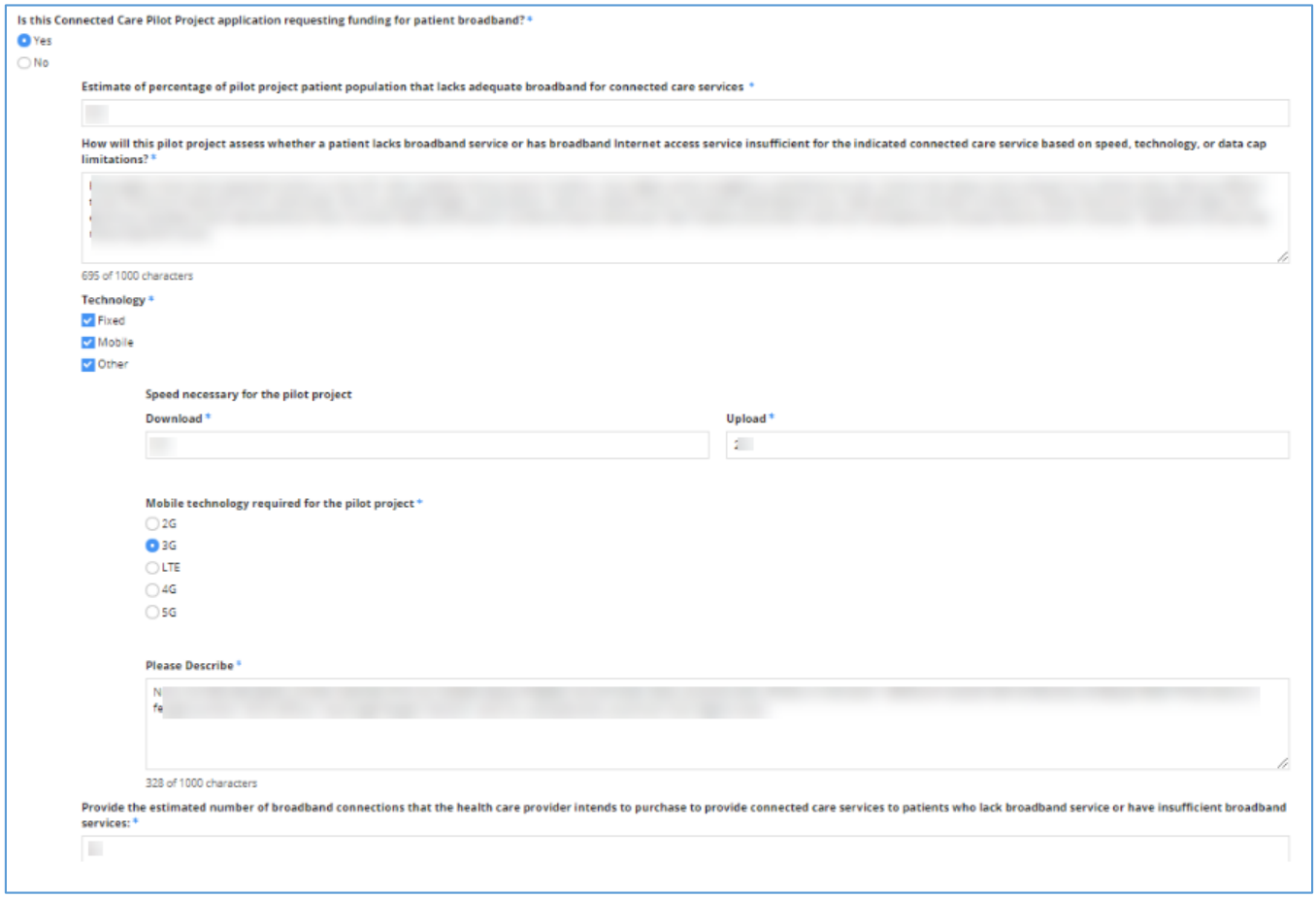


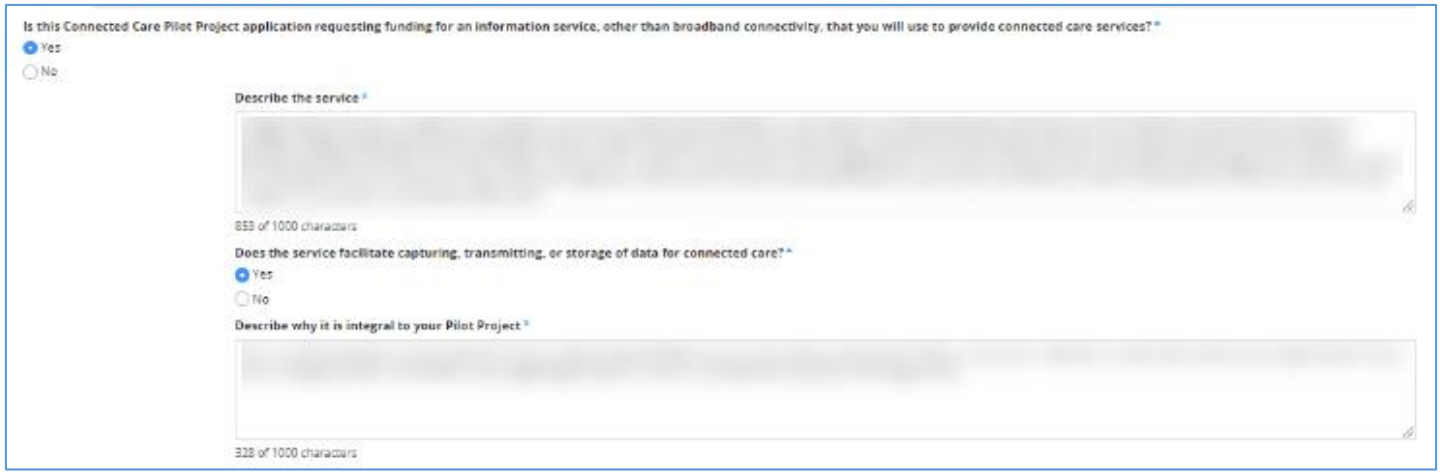
Is this Connected Care Pilot Project application requesting funding for network equipment? *

- (•) Yes
- ( ) No

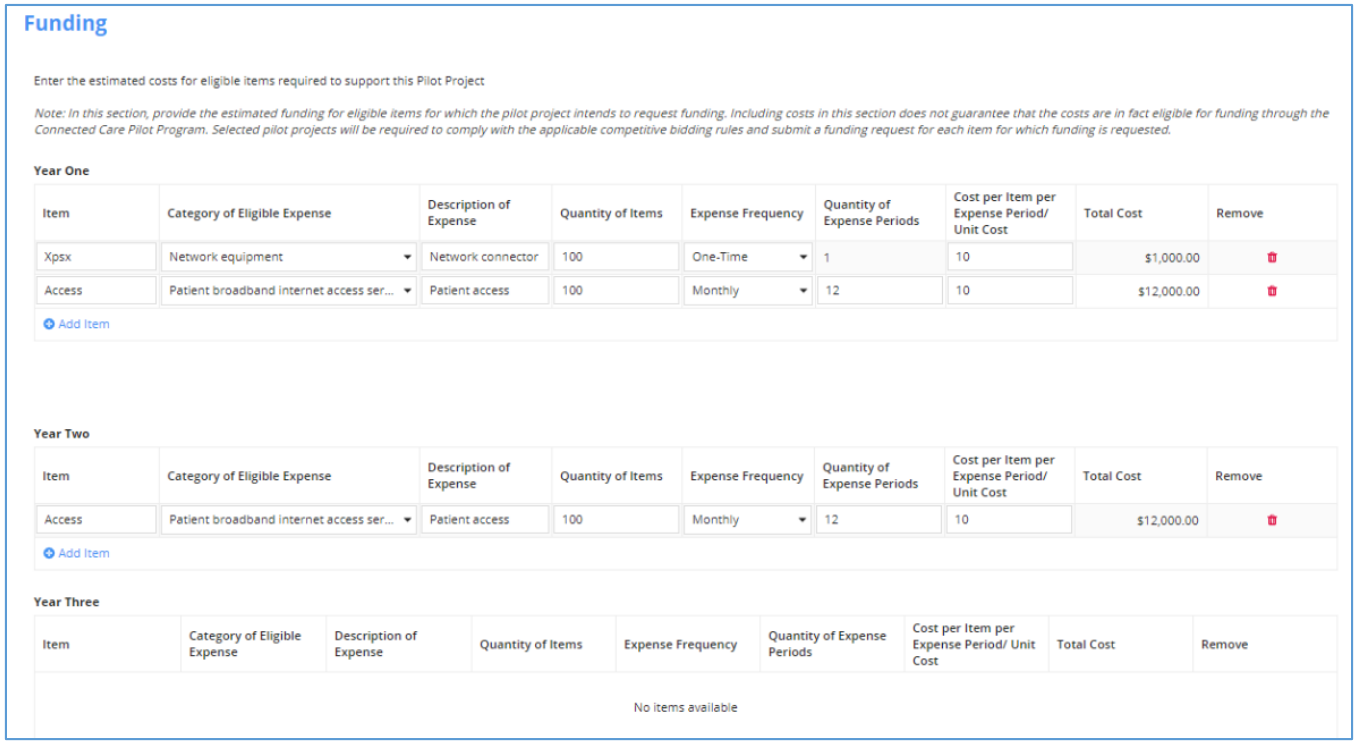
Is this Connected Care Pilot Project application requesting connectivity services for participating health care providers? *

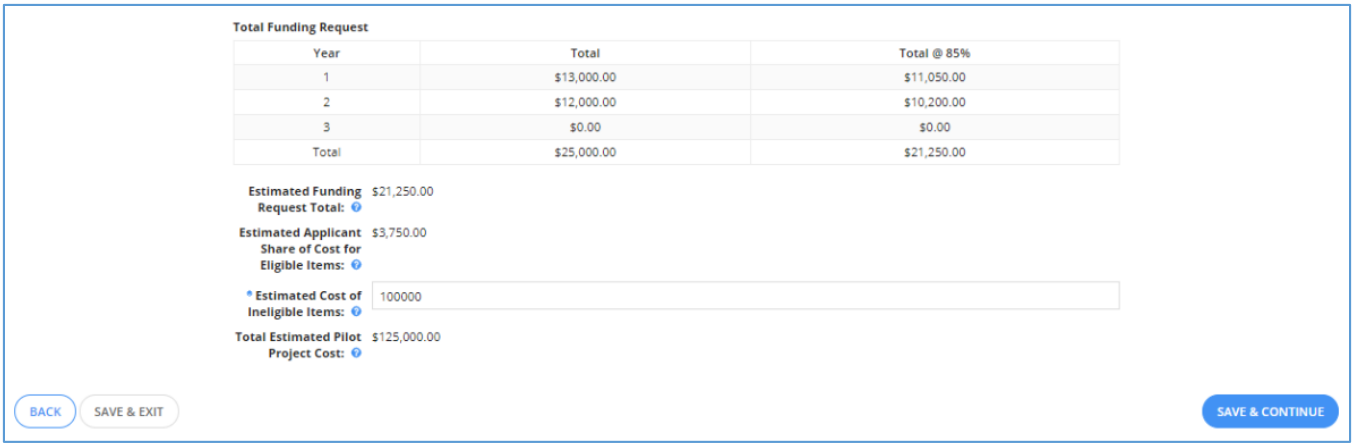
- (•) Yes
- ( ) No




Is this Connected Care Pilot Project application requesting funding for an information service, other than broadband connectivity, that you will use to provide connected care services? *
Yes
No
Describe the service *
853 of 1000 characters
Does the service facilitate capturing, transmitting, or storage of data for connected care? *
Yes
No
Describe why it is integral to your Pilot Project *
328 of 1000 characters

Funding


Funding
Enter the estimated costs for eligible items required to support this Pilot Project
Note: In this section, provide the estimated funding for eligible items for which the pilot project intends to request funding. Including costs in this section does not guarantee that the costs are in fact eligible for funding through the Connected Care Pilot Program. Selected pilot projects will be required to comply with the applicable competitive bidding rules and submit a funding request for each item for which funding is requested.
Year One
Item | Category of Eligible Expense | Description of Expense | Quantity of Items | Expense Frequency | Quantity of Expense Periods | Cost per Item per Expense Period/ Unit Cost | Total Cost | Remove
Xpsx | Network equipment | Network connector | 100 | One-Time | 1 | 10 | $1,000.00
Access | Patient broadband internet access ser... | Patient access | 100 | Monthly | 12 | 10 | $12,000.00
Add Item
Year Two
Item | Category of Eligible Expense | Description of Expense | Quantity of Items | Expense Frequency | Quantity of Expense Periods | Cost per Item per Expense Period/ Unit Cost | Total Cost | Remove
Access | Patient broadband internet access ser... | Patient access | 100 | Monthly | 12 | 10 | $12,000.00
Add Item
Year Three
Item | Category of Eligible Expense | Description of Expense | Quantity of Items | Expense Frequency | Quantity of Expense Periods | Cost per Item per Expense Period/ Unit Cost | Total Cost | Remove
No items available



Total Funding Request

Year	Total	Total @ 85%
1	$13,000.00	$11,050.00
2	$12,000.00	$10,200.00
3	$0.00	$0.00
Total	$25,000.00	$21,250.00

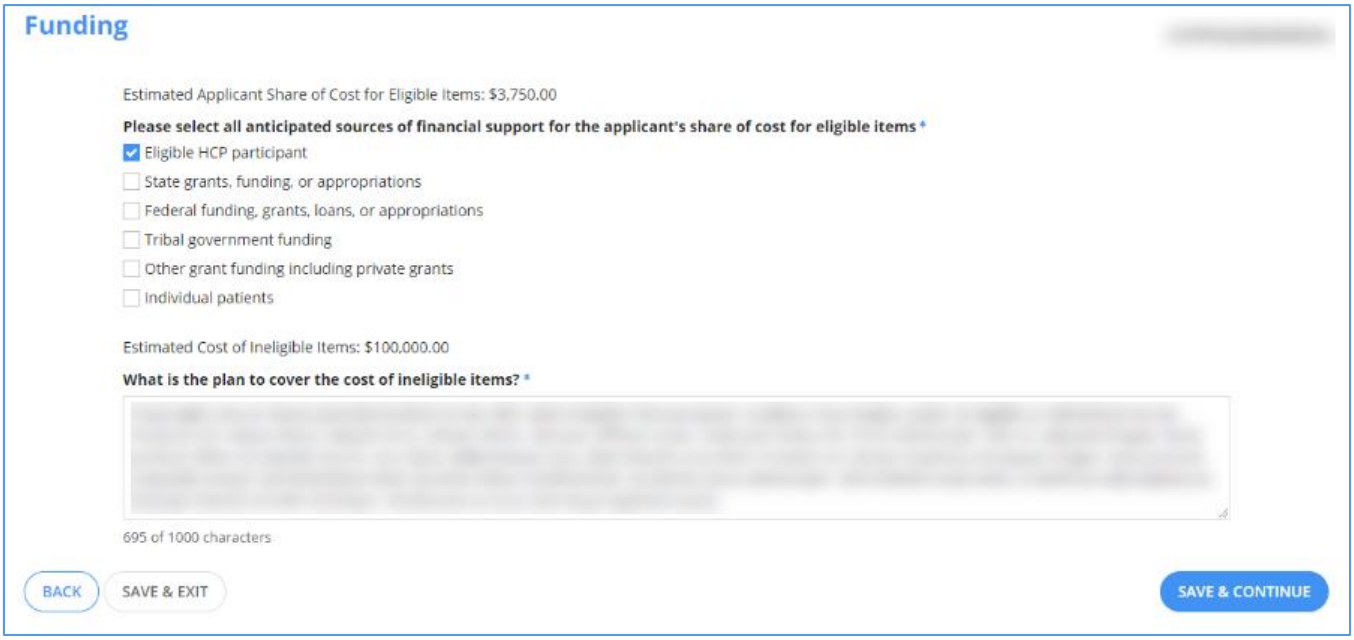
Estimated Funding Request Total: $21,250.00

Estimated Applicant Share of Cost for Eligible Items: $3,750.00

*** Estimated Cost of Ineligible Items:** 100000

Total Estimated Pilot Project Cost: $125,000.00

BACK | SAVE & EXIT | SAVE & CONTINUE



Funding

Estimated Applicant Share of Cost for Eligible Items: $3,750.00

Please select all anticipated sources of financial support for the applicant's share of cost for eligible items *

- [x] Eligible HCP participant
- [ ] State grants, funding, or appropriations
- [ ] Federal funding, grants, loans, or appropriations
- [ ] Tribal government funding
- [ ] Other grant funding including private grants
- [ ] Individual patients

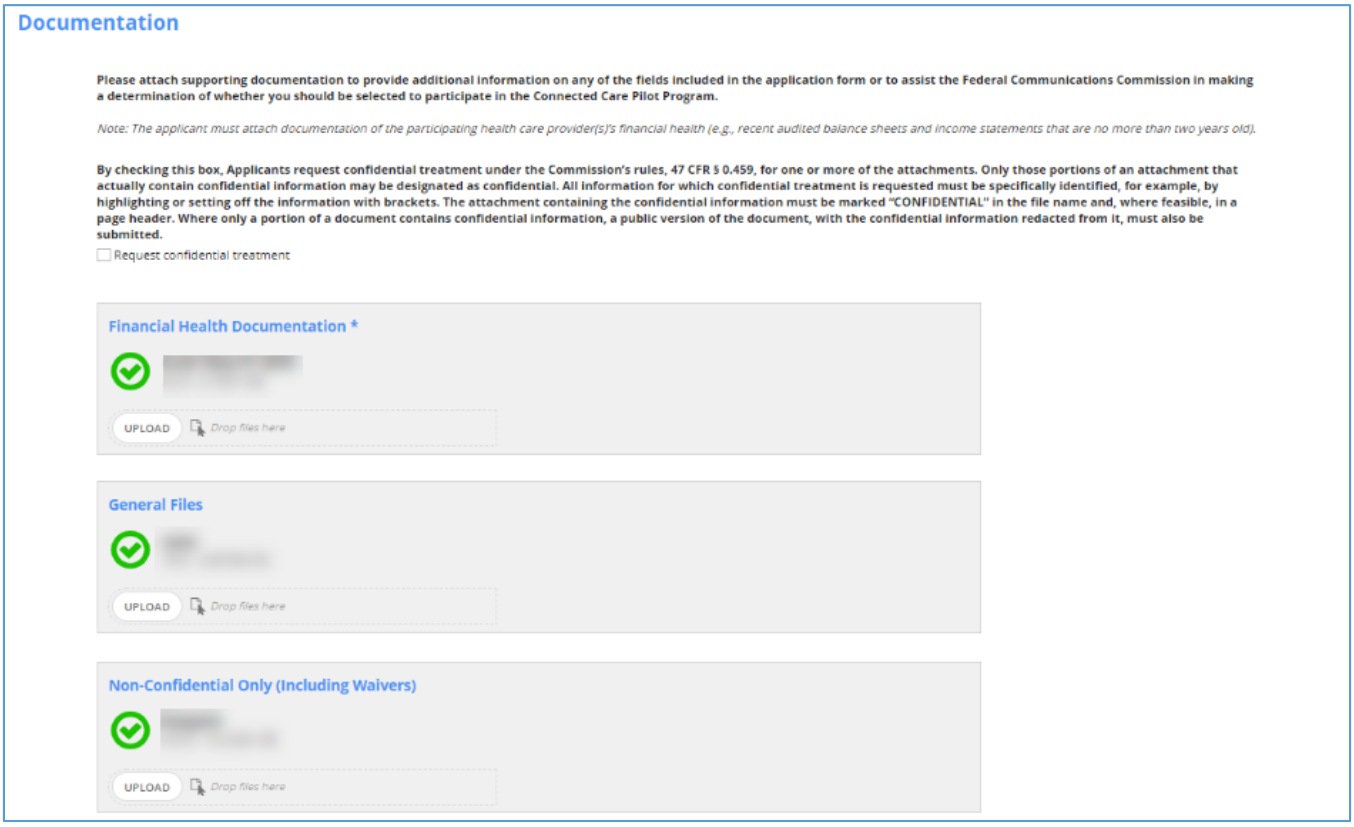
Estimated Cost of Ineligible Items: $100,000.00

What is the plan to cover the cost of ineligible items? *

695 of 1000 characters

BACK | SAVE & EXIT | SAVE & CONTINUE

Documentation



Applicants may request a waiver of FCC rules to participate in the Connected Care Pilot. When requesting a waiver, additional documentation must be included detailing the need for such a waiver (these attached materials will not be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules). Does the project need a waiver of any applicable FCC rules to participate in the Pilot Program? *

- (•) Yes
- ( ) No

Please identify the rules you wish to have waived *

0 of 1000 characters

Certifications

Select all Certifications:

- [x] I certify, under penalty of perjury, that I am authorized to submit this application on behalf of the health care provider(s) listed in the application.
- [x] I certify, under penalty of perjury, that to the best of my knowledge, information, and belief, all information contained in this application, and in any attachments, is true and correct.
- [x] I certify and acknowledge, under penalty of perjury, that if selected, the health care provider(s) in the application will comply with all applicable Connected Care Pilot Program rules, requirements and procedures, including the requirement to pay 15% of the costs for supported items from eligible sources, and all applicable federal and state laws, including the Americans with Disabilities Act, the Rehabilitation Act, the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law.
- [x] I certify and acknowledge, under penalty of perjury, that if selected, the health care providers in the application will comply with the applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws.
- [x] I certify and acknowledge, under penalty of perjury, that all documentation associated with this application must be retained for a period of at least five years after the conclusion of the participating pilot project to demonstrate compliance with the Connected Care Pilot Program rules, requirements and procedures, subject to audit.
- [x] I certify, under penalty of perjury, to the best of my knowledge, that the health care provider(s) listed in the application is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services and/or equipment eligible for support under the Connected Care Pilot Program.
- [x] I certify and acknowledge, under penalty of perjury, that all requested equipment and services funded under the Connected Care Pilot Program will be used for their intended purposes.

NOTE: To review all information on this form, select Exit to return to the home page, and then select View next to your application. You can then print the View screen if you would like a copy of your application.

Signature and Date

Certifier's Full Name:

* **Certifier's Signature:**

* **Date:**