FCC
Form 465

Approval by OMB
3060—
Expires ___ / ___/ ___

Health Care Providers Universal Service Program

Description of Services Requested and Certification

Estimated Average Burden Hours Per Response: 2.5 hours

Please read instructions before completing. (To be completed by Health Care Provider seeking Universal Service funding.)

Block 1: Applicant Information

1. Name of Applicant:	2. Federal EIN	3. Universal Service Control Number	4. Customer ID Number	5. Funding Year

6. Complete Mailing Address of Institution

Street	County	City	State	Zip Code	Telephone number

7. Contact Person's Name:

8. Mailing Address (if different from Item 6)

Street	County	City	State	Zip Code	Telephone number

FAX number	E-mail address

Block 2: Eligibility

9 The applicant (check only one):

a. ☐ is located in a non-metropolitan county as defined by the OMB Metropolitan Statistical Area list or of non-urban areas of those metro counties identified in the Goldsmith Modification used by ORHP/HHS; or

b. ☐ is not located in a of rural area, but cannot obtain toll-free access to an Internet service provider.

10. Type of Institution *(Check only one):*

a. ☐ rural health care provider
b. ☐ non-rural health care provider
c. ☐ consortium of health care providers
d. ☐ consortium of health care providers and other entities

11. *Complete Item 11 only if box 10a or 10b is checked.*

☐ If the applicant is a health care provider (not a consortium), the applicant is an eligible public or non-profit entity under 47 U.S.C. Sec 254(h)(4) because it is either a (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; or
☐ Rural health clinic.

12. *Complete Item 12 only if box 10c or 10d is checked.* If the applicant is applying as a consortium of entities, provide the following information for each entity in the consortium:

Federal EIN	Name of Entity	Type of Entity (e.g., rural health care provider, school, ineligible entity)	Zip Code	Contact name, phone number, and address	Name of nearest large city

Block 3: Description of Services Requested

13. a. Services Requested (wireline or wireless) *(Check all that apply.)*

Switched Services

- □ Voice
- □ 1.44 Kbps
- □ 1.544 Mbps
- □ ISDN
- □ Frame Relay
- □ ATM
- □ Other

Dedicated Services

- □ 64 Kbps service
- □ 1.544 Mbps service
- □ ISDN
- □ DDS
- □ Other

b. Please list any other services requested or provide a description of the application desired (e.g., the capability to transmit data and medical images such as x-rays; provider-to-patient consultation using electronic diagnostic devices, continuing medical education programs for rural health care providers).

14 Are you aware of any applicable state procurement rules? □ Yes □ No If yes, briefly describe your state's requirements.

15. a. Can the institution obtain toll-free access to an Internet service provider? □ Yes □ No (complete 15b)
b. What is the monthly toll charge incurred for thirty (30) hours of access to an Internet service provider? _____

Block 4: Supplemental Information

16. Name of nearest city in applicant's state with population of 50,000 or greater? _____

17. a. Is the institution a party to an existing contract for telecommunications services? □ Yes (complete 17b) □ No
    b. Provide the following information about the institution's **existing** service contract:

Service Provider	CONTRACT			Description of Services Received
	Number	Award Date	Expiration Date	

Block 5: Certification

18. The services that the institution purchases at rates comparable to urban rates under 47 U.S.C. Sec 254 (must check both):

- □ will be used solely for purposes reasonably related to the provision of health care service or instruction that the health care provider is legally authorized to provide under the law of the state in which the services are provided;
- □ will not be sold, resold, or transferred in consideration for money or any other thing of value.

19. □ Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the health care provider or consortium that I am representing satisfies all of the requirements below and will abide by all of the relevant requirements with respect to funding provided under 47 U.S.C. Sec. 254.

20. □ I certify that I am authorized to submit this request on behalf of the above-named institution or institutions , 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.

21. Signature	22. Date
23. Printed name of authorized person	
24. Title or position of authorized person	

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.

Return Form to:	Administrator Health Care Corporation 100 South Jefferson Road Whippany, New Jersey 07981