

**Rural Health Care (RHC) Universal Service  
 Healthcare Connect Fund  
 Request for Services Form**

USAC Internal Use Only	
FCC Form 461 Application Number:	FCC Form 460 Number:
Posting Start Date:	Posting End Date:
Allowable Contract Selection Date (ACSD):	Form 461 Friendly Name:

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

Block 1: General Information																																						
1 Funding Year	2 HCP Number																																					
3 Site Name/Consortium Name																																						
4 Address Line 1																																						
5 Address Line 2	6 County																																					
7 City	8 State	9 Zip Code																																				
Block 2: Individual HCP Site Request for Services																																						
10 <input type="checkbox"/> Applicant has prepared and is submitting an RFP with this form. <input type="checkbox"/> Applicant has not and will not prepare an RFP.																																						
10a Requested contract period																																						
10b Expected bid evaluation period																																						
11 Number of Days Posted Number of days USAC should post: _____ Posting end date: _____																																						
12 Category of Expense Requested (check all applicable): <input type="checkbox"/> Network Equipment <input type="checkbox"/> Leased/Tariffed Facilities or Services																																						
12a Identify Anticipated Application(s) and Use(s) of the Supported Connection																																						
<p>The Fund only provides support for costs associated with broadband connectivity. The additional expenses associated with specific applications (e.g., exchange of electronic health records) are not eligible for support under the Healthcare Connect Fund.</p> <p>(Select all that apply. Describe usage level and usage period for all selected.)</p> <table border="1"> <thead> <tr> <th>Capability</th> <th>Usage Level</th> <th>Usage Period</th> </tr> </thead> <tbody> <tr> <td colspan="3"><u>Category: Interactive</u></td> </tr> <tr> <td><input type="checkbox"/> Distance learning/training</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Real-time remote examination, consultation, and/or monitoring</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Video conferencing</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Voice service</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other (describe): _____</td> <td></td> <td></td> </tr> <tr> <td colspan="3"><u>Category: Transactional</u></td> </tr> <tr> <td><input type="checkbox"/> Distance learning/training</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Electronic patient billing</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Exchange of electronic health records</td> <td></td> <td></td> </tr> <tr> <td><input type="checkbox"/> Internet access</td> <td></td> <td></td> </tr> </tbody> </table>			Capability	Usage Level	Usage Period	<u>Category: Interactive</u>			<input type="checkbox"/> Distance learning/training			<input type="checkbox"/> Real-time remote examination, consultation, and/or monitoring			<input type="checkbox"/> Video conferencing			<input type="checkbox"/> Voice service			<input type="checkbox"/> Other (describe): _____			<u>Category: Transactional</u>			<input type="checkbox"/> Distance learning/training			<input type="checkbox"/> Electronic patient billing			<input type="checkbox"/> Exchange of electronic health records			<input type="checkbox"/> Internet access		
Capability	Usage Level	Usage Period																																				
<u>Category: Interactive</u>																																						
<input type="checkbox"/> Distance learning/training																																						
<input type="checkbox"/> Real-time remote examination, consultation, and/or monitoring																																						
<input type="checkbox"/> Video conferencing																																						
<input type="checkbox"/> Voice service																																						
<input type="checkbox"/> Other (describe): _____																																						
<u>Category: Transactional</u>																																						
<input type="checkbox"/> Distance learning/training																																						
<input type="checkbox"/> Electronic patient billing																																						
<input type="checkbox"/> Exchange of electronic health records																																						
<input type="checkbox"/> Internet access																																						

<input type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.)		
<input type="checkbox"/> Other (describe): _____		
<b>Category: Bulk</b>		
<input type="checkbox"/> Electronic patient billing		
<input type="checkbox"/> Exchange of electronic health records		
<input type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.)		
<input type="checkbox"/> Transmission of store and forward consultations		
<input type="checkbox"/> Other (describe): _____		
<b>Category: Miscellaneous</b>		
<input type="checkbox"/> Backup/redundant connectivity		
<input type="checkbox"/> Other (describe): _____		

12b Applicant requesting services for an off-site data center:  
 Yes                       No                      If yes, provide HCP Number: \_\_\_\_\_

12c Applicant requesting services for an off-site administrative office:  
 Yes                       No                      If yes, provide HCP Number: \_\_\_\_\_

13 Contact for Request for Services:  
 Same as HCP Physical Location Contact                       Same as HCP Primary Account Holder                       Other

**13a If other, provide full contact information:**

Contact Name	Organization Name
Contact Name Title	
Phone	Ext.
	Email

**Block 3: Consortium Request for Services**

14 Participating Entities (list all sites, eligible and ineligible, participating in this request for services):

HCP Number:	HCP Number:
HCP Number:	HCP Number:

15 Indicate whether the Consortium plans to utilize an RFP:  
 Applicant has prepared and is submitting an RFP with this form. If selected, complete 15a.  
 Applicant has not and will not prepare an RFP.

15a Applicant is submitting an RFP because:

<input type="checkbox"/> It is seeking more than \$100,000 in program support	<input type="checkbox"/> Of state, Tribal, or local procurement rules
<input type="checkbox"/> It is seeking support for infrastructure	<input type="checkbox"/> The applicant has elected to use an RFP

15b Requested contract period

15c Expected bid evaluation period

16 Number of Days Posted:  
Number of days USAC should post: \_\_\_\_\_ Posting end date: \_\_\_\_\_

17 Category of Expense Requested:

<input type="checkbox"/> Network Design	<input type="checkbox"/> Leased/Tariffed Facilities or Services
<input type="checkbox"/> Network Equipment	<input type="checkbox"/> Network Management/Maintenance/Operations Cost (not captured elsewhere)
<input type="checkbox"/> Infrastructure/Outside Plant	

**17a If requesting only Infrastructure/Outside Plant, enter FCC Form 461 Application Number in which the Consortium previously requested Leased/Tariffed Facilities or Services.**

FCC Form 461 Application Number: \_\_\_\_\_  
 I certify that the prior FCC Form 461 resulted in no responsive bids.

18 Description of Services Requested (Required to provide a summary of RFP if submitting one):

---



---

19 Contact for Request for Services:  
 Same as Project Coordinator       Same as Assistant Project Coordinator       Other

If other, provide full contact information:

Contact Name	Organization Name
Contact Name Title	
Phone	Ext.
Email	

**Block 4: Declaration of Assistance**

20 Have any consultants, service providers, or any other outside experts, whether paid or unpaid, aided in the preparation of the FCC Forms 460 or 461, RFP, bid evaluation, or network plan?  
 Yes       No

21 List the contact information for all consultants, service providers, and outside experts that assisted in preparing any part of the FCC Forms 460, 461, RFP, bid evaluation, or network plan.

a. Name (First, Middle Initial, Last)	b. Organization Type	
c. Title/Role	d. Employer	
e. Address Line 1		
f. Address Line 2		
g. City	h. State	i. Zip Code

**Block 5: Bid Evaluation**

22 Select selection criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services. Attach supplemental information (if necessary).

Criteria	Weight
a.	
b.	
c.	

**Block 6: Additional Documentation**

23 List all supporting documentation (RFP, Network Plan, etc) that is required to be submitted with this form.

Type of Documentation
a.
b.
c.

**Block 7: Certifications**

24  I certify under penalty of perjury that I am authorized to submit this request on behalf of the health care provider or consortium.

25  I declare under penalty of perjury that I have examined this form and attachments and to the best of my knowledge, information, and belief, all information contained in this form and in any attachments is true and correct.

26  I certify under penalty of perjury that the applicant has followed any applicable state, Tribal, or local procurement rules.

27  I certify under penalty of perjury that the supported connection(s) and network equipment will be used solely for purposes reasonably related to the provision of healthcare service or instruction that the health care provider is legally authorized to provide under the law of the state in which the connections are provided. In addition, I certify under penalty of perjury that the supported connection(s) and network equipment will not be sold, resold, or transferred in consideration for money or any other thing of value.

28	<input type="checkbox"/>	I certify under penalty of perjury that the applicant satisfies all of the requirements under section 254 of the Communications Act, 47 U.S.C. § 254, and applicable Commission rules.
29	<input type="checkbox"/>	I certify under penalty of perjury that the applicant has reviewed all applicable requirements for the program and will comply with those requirements.
30	<input type="checkbox"/>	I understand that all documentation associated with this form, including a copy of the signed 461, any bids/ contracts resulting from the 461 posting, scoring sheet, and other information that was used in the decision making process, must be retained for a period of at least five years pursuant to 47 C.F.R. § 54.648, or as otherwise prescribed by the Commission's rules.
31	Signature	32 Date
33	Printed Name of Authorized Person	
34	Title/Position of Authorized Person	
35	Phone Ext.	36 Email
37	Employer	38 Employer's FCC RN

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-PER, 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.