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PAUL D. TONKO
U.S. HOUSE OF REPRESENTATIVES
20TH DISTRICT, NEW YORK

COMMITTEE ON ENERGY AND COMMERCE
CHAIR, SUBCOMMITTEE ON ENVIRONMENT
AND CLIMATE CHANGE
SUBCOMMITTEE ON ENERGY
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
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COMMITTEE ON SCIENCE, SPACE,
AND TECHNOLOGY
SUBCOMMITTEE ON ENVIRONMENT
SUBCOMMITTEE ON RESEARCH AND TECHNOLOGY

May 15, 2020

431

The Honorable Ajit Pai
Chairman
Federal Communications Commission
445 12th Street SW Washington, DC 20554

Dear Chairman Pai,

I write on behalf of Albany Medical Center, located in Albany, New York, which is within my Congressional District. Albany Medical Center recently submitted an application for funding through the FCC COVID-19 Telehealth Program. I respectfully request your full and fair consideration of this application.

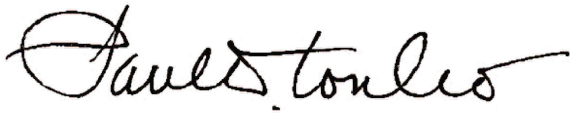
New York State continues to be the most severely impacted state in the country by the COVID-19 pandemic. As of May 13th, there have been 1,494 positive cases within Albany County alone, many of which have and continue to receive care at Albany Medical Center. Because of this, health care providers, like Albany Medical Center, have been exploring creative ways to provide quality care to their patients while protecting public health.

As per the enclosed application, Albany Medical Center would invest this grant funding in equipment required to monitor COVID-19 positive patients and patients under investigation, devices that will provide for a communication platform for care teams and networking with loved ones, and afford outpatient telehealth services for residents across a 25-county region of northeastern New York as well as western New England.

As detailed in the application, these funds are critical to the expansion of Albany Medical Center's telehealth operation throughout the Capital Region. These resources would enable medical professionals at Albany Medical Center to provide at-home treatment and monitoring services to COVID-19 patients, as well as afford a safe option for continued care for non-COVID patients, particularly those vulnerable populations such as senior citizens, young children and individuals with chronic conditions who are at an increased risk for contracting the virus.

Your consideration of Albany Medical Center's application, consistent with all federal laws, rules, regulations and agency policies, is appreciated.

Sincerely,

A handwritten signature in black ink that reads "Paul D. Tonko". The signature is written in a cursive style with a large initial "P" and a long horizontal flourish at the end.

Paul D. Tonko
Member of Congress

COVID-19 Telehealth Application



Applicants should submit their completed application form and all supporting documentation to TelehealthApplicationSupport@fcc.gov

Applicant Information [all fields mandatory unless otherwise marked]

Applicant Name	Applicant FCC Registration Number (FRN)	Applicant National Provider Identifier (Optional)
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Federal Employer Identification Number (EIN or Tax ID Number)

Data Universal Numbering System (DUNS) Number

DATA Act Business Types (choose Three)

- A - State Government
- B - County Government
- C - City or Township Government
- D - Special District Government
- E - Regional Organization
- F - U.S. Territory or Possession
- G - Independent School District
- H - Public/State Controlled Institution of Higher Education
- I - Indian/Native American Tribal Government (Federally-Recognized)
- J - Indian/Native American Tribal Government (Other than Federally-Recognized)
- K - Indian/Native American Tribal Designated Organization
- L - Public/Indian Housing Authority
- M - Nonprofit with 501C3 IRS Status (Other than an Institution of Higher Education)
- N - Nonprofit without 501C3 IRS Status (Other than an Institution of Higher Education)
- O - Private Institution of Higher Education
- P - Individual
- Q - For-Profit Organization (Other than Small Business)
- R - Small Business
- S - Hispanic-serving Institution
- T - Historically Black College or University (HBCU)
- U - Tribally Controlled College or University (TCCU)
- V - Alaska Native and Native Hawaiian Serving Institutions
- W - Non-domestic (non-U.S.) Entity
- X - Other

Service Area

Contact Information [all fields mandatory]

First Name

Last Name

Position Title, Company Name

Mailing Address

Street

City

State

Zip

Phone Number

E-mail Address

Health Care Provider(s) (HCP) Information [lead fields mandatory unless otherwise noted]

Lead HCP

Facility Name

Is the Facility a Hospital?

Yes

No

Street

City

State

Zip

County in which address is located

FCC Registration Number
(FRN)

HCP Number (Optional)

Eligibility Type

NPI (Optional)

Total Patient Population

Estimated Number of Patients to be
Served by Funding Request

Additional Information on Patient Estimate (Optional)

Health Care Provider(s) (HCP) Information [HCP Two- Optional fields]

Secondary HCP

Facility Name

Is the Facility a Hospital?

Yes

No

Street

City

State

Zip

County in which address is located

FCC Registration Number
(FRN)

HCP Number (Optional)

Eligibility Type

NPI (Optional)

Total Patient Population

Estimated Number of Patients to be Served by Funding Request

Additional Information on Patient Estimate (Optional)

Medical Services To Be Provided with COVID-19 Telehealth Funding (check all that apply)

Patient-Based Internet-Connected Remote Monitoring

Other Monitoring

Video Consults

Voice Consults

Imaging Diagnostics

Other Diagnostics

Remote Treatment

Other services

Additional Information on Medical Services to be Provided:

Conditions To Be Treated with COVID-19 Telehealth Funding (answer all that apply)

Would you treat COVID-19 patients directly?

Yes

No

Would you treat patients without COVID-19 symptoms or conditions?

Yes

No

If you answered "Yes" to the above question, please check at least one box below

Other infectious diseases

Emergency / Urgent Care

Routine, Non-Urgent Care

Mental Health Services (non-emergency)

Other conditions

Additional Information on Specific Conditions to be Treated:[Required if other conditions is selected]

If yes, please explain how using COVID-19 Telehealth Program funding to treat patients without COVID-19 symptoms or conditions would free up resources that will be used to treat COVID-19. (Required if yes)

Additional Information Concerning Requested Services and Devices

What are your goals and objectives for use of the COVID-19 Telehealth Program Funding?

What is your timeline for deployment of the proposed service(s) or devices funded by the COVID-19 Telehealth Program?

What factors/metrics will you use to help measure the impact of the services and devices funded by the COVID-19 Telehealth Program?

How has COVID-19 affected health care in your geographic area (e.g, county)?

Please provide additional information about the geographic area and population you serve. Does it have large underserved or low-income patient population? Have there been recent health care provider closures or other health care deficiencies? If so, please describe such factors (Optional)

Do you plan to target the funding to high-risk and vulnerable patients?

Yes

No

If so, please describe how.

Please provide any additional information to support your application and request for funding (Optional)

Requested Funding Items

Total Amount of Funding Requested

Are you requesting funding for devices?

Yes

No

How are the devices integral to patient care?

Are the devices for patient use?

Yes

No

Are the devices for the health care provider's use?

Yes

No

Category (Optional)

Description of Service(s) and/or Device(s)(Optional)

Quantity (for Devices)(Optional)

Total One-Time Expense(Optional)

Date [Purchased or] To Be Purchased(Optional)

Total Monthly Expense(Optional)

Number of Months for Recurring Monthly Expenses(Optional)

Supporting Cost and Estimated Patient Documentation

An applicant should provide supporting documentation for the costs indicated in its application. Such supporting documentation should summarize the expected costs of the eligible services and devices requested and may include documentation such as an invoice or quote from a vendor or service provider (or similar information). Such information should be specific enough to identify line-items to facilitate swift review of the application, and we encourage applicants to include information such as a description of the service or device, its eligibility category, the quantity ordered, the upfront and monthly expenses, and the service dates for recurring services. Additionally, applicants may provide supporting document for the estimated number of patients to be served by the funding request.

Request for confidential treatment of supporting documentation?

Yes No

Applicant requests Confidential treatment for supporting documents and information. By designating supporting documents and information as "Confidential," the applicant is deemed to have submitted a request that the material be withheld from public inspection pursuant to 47 CFR § 0.459. Applicants designating supporting documents as "Confidential" should not submit those documents in the Commission's Electronic Comment Filing System (ECFS). Email Confidential materials to TelehealthApplicationSupport@fcc.gov

Certifications

[Applicant must check all boxes and sign]

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.

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.

I understand that, if selected, the health care provider(s) in the application must comply with all applicable program requirements and procedures, and all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law, as waived or modified in connection with the COVID-19 pandemic, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

I understand that, if selected, the health care providers in the application must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws, as waived or modified in connection with the COVID-19 pandemic.

I understand that all documentation associated with this application must be retained for a period of at least three years after the last date of delivery of the supported-services provided through the COVID-19 Telehealth Program to demonstrate compliance with COVID-19 Telehealth Program rules and requirements, subject to audit.

I certify under penalty of perjury that the health care provider(s) listed in the application, to the best of my knowledge, is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services or devices eligible for support under the COVID-19 Telehealth Program.

I understand that all requested goods and services funded under the COVID-19 Telehealth Program must be used for their intended purposes.

Contact Name

Date

If you have an issue with this form and/or need assistance please contact: TelehealthApplicationSupport@fcc.gov.