

# DRAFT

FCC Form [HC-1]

## Health Care Providers Universal Service Program Description of Services Requested and Certification

Approval by OMB

3060-\_\_\_\_\_

Expires \_\_\_/\_\_\_/\_\_\_

Please read instructions before completing.

(To be completed by Health Care Provider seeking  
Universal Service funding.)

Estimated Average Burden Hours Per Response: 1.5 hours

### Block 1: Applicant Information

1	Name of Applicant	2 Federal EIN	3 Universal Service Control Number
4	Type of institution (check only one): <input type="checkbox"/> rural health care provider <input type="checkbox"/> consortium of health care providers and/or other entities <input type="checkbox"/> non-rural health care provider		
5	Complete Mailing Address of Institution		
	Street	City	State      Zip Code
	County	Telephone number	
6	Contact Person's Name		
	Mailing Address (if different from Item 5)		
	City	State	Zip Code      Telephone number
	Fax number	E-mail address	

### Block 2: Description of Services Requested

7 a. Services Requested (Check all that apply)

<p><b>Switched Services</b></p> <input type="checkbox"/> Voice <input type="checkbox"/> 1.44 Kbps <input type="checkbox"/> 1.544 Mbps <input type="checkbox"/> Frame Relay (wireline or wireless) <input type="checkbox"/> ATM (wireline or wireless) <input type="checkbox"/> Other	<p><b>Dedicated Services</b></p> <input type="checkbox"/> 64 Kbps service <input type="checkbox"/> 1.544 Mbps service <input type="checkbox"/> DDS (wireline or wireless) <input type="checkbox"/> Other
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b. Please list any other services requested or provide a description of the application desired (e.g., X-ray transmission).

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8  Check here if institution has prepared a request for proposal (RFP) associated with any of these services and either give website address where it is posted \_\_\_\_\_ or make sure that the contact person (in 5 above) has access to it.

If the institution has not prepared an RFP, are you aware of any applicable state procurement rules?    Yes     No   

If yes, briefly describe your state's requirements.

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9 a. Can the institution obtain toll-free access to the Internet?     Yes     No (complete 9b)

b. What is the monthly toll charge incurred for thirty (30) hours of access to the Internet?

### Block 3: Supplemental Information

10 Name of nearest city with population of 50,000 or greater

11 a. Is the institution a party to an existing contract for telecommunications or Internet services?     Yes (complete 11b)     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	

# DRAFT

**Block 4: Consortium Participants**

12 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 e-mail address	Name of nearest large city

**Block 5: Certificate of Eligibility**

13  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.

14 The institution 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.

15 The institution (check only one):

- serves residents of 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
- does not serve residents of rural areas, but cannot obtain toll-free access to an Internet service provider.

16 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.

17  I certify that I am authorized to submit this request on behalf of the above-named institution, that I have examined this request and to the best of my knowledge, information and belief, all statements of fact contained herein are true.

18 Signature

19 Date

20 Printed name of authorized person

21 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**



# DRAFT

FCC Form [HC-3]

## Health Care Providers Universal Service Program Telecommunications Support Worksheet

Approval by OMB

3060- \_\_\_\_\_

Expires \_\_\_\_/\_\_\_\_/\_\_\_\_

Please read instructions before completing.

(To be completed by Telecommunications Carriers.)

Estimated Average Burden Hours Per Response: 1.5 hours

### Applicant Information

1 Name of Rural Health Care Facility to be served	2 Customer ID Number	3 Federal EIN	4 Application Control Number
5 Selected Service Provider Name			
6 Mailing Address			
Street	City	State	Zip Code
7 Contact Person's Name	8 Telephone number ( ) -	9 FAX number ( ) -	
10 E-mail address			

### Calculation of Rates:

11 Applicable rural rate(s) (Show how rate is calculated.*)		
12 Applicable urban rate(s) (Show how rate is calculated.*)		
13 Applicable discount *		
* (You may attach Discount Worksheet to show calculations.)		

### Certification Statement

14 <input type="checkbox"/> I hereby certify that the service provider is an eligible telecommunications provider under Section 254(e) of the Act and has been designated eligible by its state commission to provide supported telecommunications services to health care facilities (unless providing only toll-free or local dial-up access to the Internet Service Provider). I also certify that:	
a) All services are being provided to an eligible health care facility;	
b) Adequate records of use are maintained by the service provider in cases where the health care facility is a member of a consortium; and	
c) Adequate records of use are maintained by the service provider in cases where the health care facility uses its facilities for multiple purposes.	
15 <input type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named service provider, and that to the best of my knowledge, and belief, the information in this application is complete, accurate and consistent with FCC Rules.	
16 Signature	17 Date
18 Printed name of certifying officer / employee	
19 Title or position of certifying officer / employee	

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