

Health Care Providers Universal Service  
**Internet Service Funding Request and Certification Form**  
(And Advanced Services Funding Request and Certification for Entirely Rural States)

The Deadline to submit this Form is the June 30th End of the Funding Year. Estimated time per response: 1 hour  
Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

**Block 1: HCP Information**

1 HCP Name	Sample Valley Hospital	2 HCP Number	123456
3 Form 465 Application #	USAC's USE	4 Consortium Name (If any)	Sample Pilot Project

**Block 2: Bill Payer Information**

5 Billed Entity Name	Sample Valley Hospital	6 Billed Entity's FCC RN	123456789
7 Contact Name	Mary Sample (Project Coordinator)		
8 Address Line 1	123 Main Street		
9 Address Line 2			
10 City	Samletown	11 State	PA
		12 Zip	13245
13 Contact Phone #	123-456-7890	14 Fax #	321-654-9870
15 E-Mail	mary@SVH.org		

**Block 3: Funding Year Information**

16 Funding Year - Check only one box  
 Year 2005 (7/1/2005-6/30/2006)   
 Year 2006 (7/1/2006-6/30/2007)   
 Year 2007 (7/1/2007-6/30/2008)

**Block 4: Service Information**

17 Give a brief description of the service for which support is requested:  
**Network Design Study**

18 Percentage of HCP's service used for the provision of health care. (If less than 100%, please explain.)  
**100% (If your project has mixed entities with regard to eligibility, please choose a percentage that represents the eligible entity's use. You will need to supply supporting documentation.)**

19 Location where service is provided: **For the paper form, this will be the location of the responsible entity**

20 Service Provider Name **Network Design Consulting Company**

21 Service Provider Identification Number (SPIN)	654987256	22 Billing Account Number	521456
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23 Contract Number (NA if no contract)	23657489	24 Date contract signed or service selected	02/29/08
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25 Contract Expiration Date (NA if no contract)	2/28/2009	26 Expected Service Start Date	
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27 Were bids received in response to Form 465?   
 Yes   
 No   
If yes, submit copies.

**Block 5: Cost of Service**

28 Installation Charge (If applicable): Total of Non-recurring charges	<b>\$50,000.00</b>	29 Monthly rate charge (Enclose documentation): Total recurring charges	
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**Block 6: Certification**

30  I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.

31  Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.

32  I hereby certify that the billed entity requesting reduced rates will maintain complete records for the service for five years.

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

34 Signature	Mary Sample's Signature	35 Date	3/5/2008
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36 Printed name of authorized person	Mary Sample	37 Title or position of authorized person	CFO
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38 Employer of authorized person	Sample Valley Hospital	39 Employer's FCC RN	123456789
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**Please remember:**

- ♦ An applicant may not file a Form 466-A until after signing the contract or otherwise selecting a service provider
- ♦ **The HCP or its authorized representative must wait at least 28 days from the Form 465 posting date before signing the contract or otherwise selecting a service provider.**
- ♦ You must be authorized to provide the information required by Form 466-A on behalf of the HCP, and you must sign and date the form.
- ♦ **Provide data for all items that apply. Attach additional sheets if necessary. Any attachments to Form 466-A must be clearly labeled.**

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 data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). 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-PERM, 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 [jboley@fcc.gov](mailto:jboley@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.

This form should be submitted to:  
Rural Health Care Pilot Program  
100 S. Jefferson Rd.  
Whippany, NJ 07981