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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): ☐ rural health care provider ☐ consortium of health care providers and/or other entities ☐ 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)

Switched Services

- ☐ Voice
- ☐ 1.44 Kbps
- ☐ 1.544 Mbps
- ☐ Frame Relay (wireline or wireless)
- ☐ ATM (wireline or wireless)
- ☐ Other

Dedicated Services

- ☐ 64 Kbps service
- ☐ 1.544 Mbps service
- ☐ DDS (wireline or wireless)
- ☐ Other

b. Please list any other services requested or provide a description of the application desired (e.g., X-ray transmission).

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.

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	

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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

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FCC Form [HC-2]

Health Care Providers Universal Service Program
Services Ordered 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: 2.5 hours

Block 1: Subscriber Information

1 Name of Applicant	2 Federal Employer Information Number (EIN)	3 Universal Service Control Number

4 Type of institution (check only one): ☐ rural health care provider ☐ non-rural health care provider ☐ consortium of health care providers and/or other entities

5 Complete Mailing Address of Institution

Street | City | State | Zip Code

County | Telephone number

6 Contact Person's Name

Mailing Address

City | State | Zip Code

Fax number | E-mail address | Telephone number

Block 2: Services Ordered (Attach copy of all responses to request for service.)

7 a. The institution(s) ordered the following service(s) from the following provider(s). (Attach additional sheets if necessary. Attach a copy of the service contract.)

Employer Identification Number	Services Ordered	Date Service Scheduled to Commence	Name of Service Provider	Rate for Contracted Services

b. Provide the total estimated cost that the institution will be required to pay under any contract listed in 7a during the next calendar year. $ _____

Block 3: Certification

8 ☐ I certify that the above-named institution has considered all bids received and selected the most cost effective method of providing the requested service or services, where the most cost effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care facility deems relevant to choosing a method of providing the required health care services.

9 ☐ 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 to the best of my knowledge, information and belief, all statements of fact contained herein are true.

10 Signature	11 Date

12 Printed name of authorized person

13 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

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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 ☐ 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 ☐ 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	

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

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FCC Form [HC-4]

Health Care Providers Universal Service Program
Receipt of Service Confirmation

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: Subscriber Information

1 Name of Applicant

2 Federal EIN

3 Universal Service Control Number

4 Type of institution (check only one): ☐ rural health care provider ☐ consortium of health care providers and/or other private entities ☐ non-rural health care provider

5 Complete Mailing Address of Institution

Street City State Zip Code

County Telephone number

6 Contact Person's Name

7 Mailing Address

City County State Zip Code Telephone number

Fax number E-mail address

Block 2: Services Received

8 Provide the following information about the services received.

Service Provider	Services Received	Date Service Commenced	Contract Total Amount

Block 3: Certification

9 I certify that the services listed above have been or are being provided to the above-named institution. I certify that I am authorized to submit this request on behalf of the above-named institution, and that to the best of my knowledge and belief, all statements of fact contained herein are true.

10 Signature

11 Date

12 Printed name of authorized person

13 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