OKLAHOMA TELEMEDICINE AFFIDAVIT IN SUPPORT OF REQUEST FOR SPECIAL UNIVERSAL SERVICES

DISCLAIMER: Please be advised that this Oklahoma Telemedicine Affidavit in Support of Request for Special Universal Services ("Affidavit"), along with all requested information must be returned to your telecommunications carrier as part of the Application for Oklahoma Universal Service Fund ("OUSF") funding. Effective immediately, this Affidavit shall replace the HB 1815. Failure to provide any of the requested information may result in a denial of OUSF funding.

DATE OF AFFIDAVIT:

LEGAL NAME OF HEALTHCARE ENTITY:

OPERATIONAL NAME OF HEALTHCARE ENTITY:

ENTITY OWNED BY:

ENTITY MANAGED BY:

ADDRESS OF ENTITY, AS LISTED IN THE APPLICATION:

NAME AND TITLE OF AFFIANT COMPLETING THIS AFFIDAVIT:

Please include address, telephone number, and e-mail address.

TYPE OF ENTITY:

- ☐ County Health Departments
- ☐ City-County Health Department
- ☐ Community Mental Health Center (OAC 450:17), Community-Based Structured Crisis Center (OAC 450:23), or Community Comprehensive Addiction Recovery Center (OAC 450:24)
- ☐ Department of Corrections Facility
- ☐ Federally Qualified Health Center (FQHC) - Includes a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act
- ☐ Not-for-Profit Hospital
- ☐ ODMHSAS Operated Facility

1. Please provide all certificates/licenses indicating entity qualifies as one of the facilities listed above.

PRIOR TELECOMMUNICATIONS CARRIER INFORMATION

PRIOR TELECOMMUNICATIONS CARRIER:

PRIOR BANDWIDTH PROVIDED:

TOTAL MONTHLY CHARGE:

DISCONNECT DATE:

2. Please provide a copy of the verification of disconnect date or the disconnect notice.

NEW TELECOMMUNICATIONS CARRIER INFORMATION FOR WHICH FUNDING IS BEING REQUESTED

TELECOMMUNICATIONS CARRIER NAME:

TELEMEDICINE BANDWIDTH PROVIDED:

TOTAL MONTHLY CHARGE:

3. Please provide all monthly invoices from the beginning of your contract/agreement with the new telecommunications carrier to the present.

4. Please provide a copy of your contract with the new telecommunications carrier.

5. Please provide a detailed list of all telemedicine applications, hardware, modalities, and software utilizing the telemedicine line for telemedicine purposes and the date for which each was installed.

IF APPLICABLE, PLEASE PROVIDE INFORMATION ON HOW YOU STORE ANY IMAGING AND BACK-UP EMR/ EHR USING THIS TELEMEDICINE LINE.

LIST ANY USE OF THE TELEMEDICINE LINE <u>OUTSIDE</u> OF THE TELEMEDICINE APPLICATIONS, HARDWARE, MODALITIES, AND SOFTWARE LISTED IN THE QUESTION ABOVE (I.E., BILLING, PUBLIC WIFI, SCHEDULING, SECURITY CAMERAS, ETC.).

6. If available, please provide a bandwidth utilization study. PUD suggests a minimum of three (3) months.

7. Please provide a detailed network diagram, including but not limited to: circuit identifications, all lines to facility(ies), bandwidth on each, identification of all service providers, etc.

DO YOU USE THE SERVICES OF A CONSULTANT? ☐ Yes ☐ No

If "yes," please provide the name and contact information of the Consultant.

8. Please provide a Letter of Agency, which authorizes the Consultant to speak with the Commission.

DID THE TELECOMMUNICATIONS CARRIER ASSIST YOU IN THE DEVELOPMENT OF YOUR RFP? ☐ Yes ☐ No

DID YOU POST YOUR RFP? ☐ Yes ☐ No

DID YOU COMPETITIVELY BID THE SPECIAL UNIVERSAL SERVICES FOR WHICH YOU ARE REQUESTING FUNDING? ☐ Yes ☐ No

HOW MANY BIDS WERE RECEIVED? PLEASE INCLUDE ANY WRITTEN BIDS OR BID INQUIRIES.

Please name any additional telecommunications carriers who placed bids or made bid inquiries.

9. Please provide copies of any communications between the entity and any potential telecommunications carrier, prior to the issuance of a RFP, or selection of a telecommunications carrier.

DID YOU SELECT THE LOWEST COST BIDDER ("LCB")? ☐ Yes ☐ No

If you did <u>not</u> select the LCB, please provide a detailed explanation as to the reason for your decision.

WERE THERE ANY BIDS THAT WERE <u>NOT</u> CONSIDERED? ☐ Yes ☐ No

If there were bids that were <u>not</u> considered, please explain why you chose <u>not</u> to consider them.

DID THE WINNING BIDDER PROVIDE MORE THAN THE MINIMUM BANDWIDTH, AS REQUESTED IN THE RFP?

☐ Yes

☐ No

How much bandwidth was provided? _____

What bandwidth range was requested in the RFP? _____

PLEASE LIST ALL EQUIPMENT PROVIDED BY THE CURRENT TELECOMMUNICATIONS CARRIER, AS PART OF THE CONTRACT FOR INTERNET, WAN SERVICE, ETC.

PLEASE LIST ALL PAYMENTS MADE FOR EQUIPMENT OR OTHER ITEMS, SEPARATE FROM THE CHARGE(S) OR FEES FOR THE TELEMEDICINE LINE:

PLEASE LIST ALL SERVICES OR SUPPORT, PROVIDED AS PART OF THE CONTRACT:

PLEASE LIST ALL CHARGES OR FEES FOR ALL SERVICES OR SUPPORT PROVIDED, SEPARATE FROM THE CHARGE(S) OR FEES FOR BANDWIDTH:

PLEASE LIST ANY AND ALL BENEFITS, INCLUDING BUT NOT LIMITED TO: GIFTS, INDUCEMENTS, INCENTIVES, OR PROMOTIONS, RECEIVED IN CONJUNTION WITH EITHER THE REQUEST FOR PROPOSAL OR PROVISION OF THE TELEMEDICINE SERVICES, WHETHER OR NOT THE BENEFIT(S) WAS OF VALUE OR NOT, FROM ANY BIDDER, FOR THE CURRENT CONTRACT PERIOD, ALL RENEWALS, AND TWO (2) YEARS PRIOR TO:

OTHER SOURCES OF FUNDING

IS THE ENTITY ELIGIBLE FOR ANY OTHER GOVERNMENT SOURCES OF FUNDING FOR THE TELEMEDICINE LINE THAT MAY ASSIST IN THE PAYMENT OF TELEMEDICINE SERVICES? ☐ Yes ☐ No

IS THE ENTITY ELIGIBLE FOR RURAL HEALTHCARE FUNDING (I.E., HEALTHCARE CONNECT FUND OR TELECOMMUNICATIONS PROGRAM)? ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO THE QUESTION ABOVE, PLEASE ANSWER THE FOLLOWING QUESTIONS:

Have you applied for Rural Healthcare Funding? ☐ Yes ☐ No

Which Rural Healthcare Funding Program did you apply for? ☐ Healthcare Connect Fund ☐ Telecommunications Program

What year(s) did you apply for Rural Healthcare Funding? ☐ 2013 ☐ 2014 ☐ 2015

IF YOU ANSWERED "NO" TO THE QUESTION ABOVE, PLEASE ANSWER THE THE FOLLOWING QUESTION:

Have you verified through the USAC website that the entity is ineligible for Rural Healthcare Funding? ☐ Yes ☐ No

If the answer to this questions is "NO," please go to the following website and provide a copy of the documentation provided, which verifies the entity is ineligible: http://www.usac.org/rhc/telecommunications/tools/Rural/search/search.asp

FOR EACH FORM LISTED BELOW, PLEASE MARK THE BOX NEXT TO EACH YEAR THAT THE ENTITY COMPLETED THE CORRESPONDING FORM.

Form 460	☐ 2013	☐ 2014	☐ 2015
Form 461	☐ 2013	☐ 2014	☐ 2015
Form 462	☐ 2013	☐ 2014	☐ 2015
Form 463	☐ 2013	☐ 2014	☐ 2015
Form 465	☐ 2013	☐ 2014	☐ 2015
Form 466	☐ 2013	☐ 2014	☐ 2015
Form 467	☐ 2013	☐ 2014	☐ 2015

10. Please provide copies of all forms listed above for each year that you identified as being completed.

IF YOU DID NOT APPLY FOR RURAL HEALTHCARE FUNDING, PLEASE EXPLAIN IN DETAIL WHY YOU CHOSE NOT TO.

ATTACHMENT CHECK LIST

Each of your attachments must be labeled according to the numbers listed in the check list below. For any attachment not included, please provide a detailed explanation as to why it is either not applicable or not available from your entity.

Attachment 1
Healthcare entity qualification certificate/license

☐ Included
☐ Not Applicable

Attachment 2
Copy of the verification of disconnect date or the disconnect notice

☐ Included
☐ Not Applicable

Attachment 3
Copies of all monthly invoices from the beginning of your contract/agreement with the new telecommunications carrier to the present

☐ Included
☐ Not Applicable

Attachment 4
Copy of your contract with the new telecommunications carrier

☐ Included
☐ Not Applicable

Attachment 5
Detailed list of all telemedicine applications, hardware, modalities, and software, utilizing the telemedicine line for telemedicine purposes and the date in which each was installed

☐ Included
☐ Not Applicable

Attachment 6
Bandwidth utilization study

☐ Included
☐ Not Applicable

Attachment 7
Detailed network diagram

☐ Included
☐ Not Applicable

Attachment 8
Letter of Agency from any and all consultants used

☐ Included
☐ Not Applicable

Attachment 9
Copies of any communications between the entity and any potential telecommunications carrier, prior to the issuance of a RFP, or selection of a telecommunications carrier

☐ Included
☐ Not Applicable

Attachment 10	All Form 460's	☐ Included	☐ Not Applicable
Attachment 11	All Form 461's	☐ Included	☐ Not Applicable
Attachment 12	All Form 462's	☐ Included	☐ Not Applicable
Attachment 13	All Form 463's	☐ Included	☐ Not Applicable
Attachment 14	All Form 464's	☐ Included	☐ Not Applicable
Attachment 15	All Form 465's	☐ Included	☐ Not Applicable
Attachment 16	All Form 466's	☐ Included	☐ Not Applicable
Attachment 17	All Form 467's	☐ Included	☐ Not Applicable

(Attachment 10 through Attachment 17 explanation box)

Attachment 18 USAC verification of ineligibility for Rural Healthcare Funding

☐ Included
☐ Not Applicable

VERIFICATION

STATE OF OKLAHOMA)
) ss:
COUNTY OF _____)

I, _____, Affiant, certify that on this _____ day of _____, 201____, that the information contained in the above and foregoing Oklahoma Telemedicine Affidavit in Support of Request for Special Universal Services, is true and correct to the best of my knowledge and that each and every attachment included, has been properly labeled as requested above.

_____ _____
TITLE OF AFFIANT SIGNATURE OF AFFIANT

Now on this _____ day of _____, 20____, the Affiant, _____ did personally appear before me and state that _____he / _____she attests that the information contained in the above and foregoing Oklahoma Telemedicine Affidavit in Support of Request for Special Universal Services, is true and correct to the best of _____his/_____her knowledge and that each and every attachment included has been properly labeled as requested above.

_____
NOTARY PUBLIC

My Commission Expires: _____

[S E A L]

My Commission Number: _____