

**Health Care Providers Universal Service
Description of Services Requested & Certification Form**

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Form 465 Application Number (assigned by RHCD)

Block 1: HCP Location Information

Information required in this block applies to the **physical location** of the HCP. Do not enter a "PO Box" or "Rural Route" address.

1 HCP Number		2 Consortium Name	
3 HCP Name		4 HCP FCC Registration Number (FCC RN)	
5 Contact Name			
6 Address Line 1			
7 Address Line 2		8 County	
9 City		10 State	11 ZIP Code
12 Phone #	13 Fax #	14 E-mail	

Block 2: HCP Mailing Contact Information

15 Is the HCP's mailing address (where correspondence should be sent) different from its physical location described in Block 1?		<input type="checkbox"/> Yes, complete Block 2	
		<input type="checkbox"/> No, go to Block 3.	
16 Contact Name		17 Organization	
18 Address Line 1			
19 Address Line 2			
20 City		21 State	22 ZIP Code
23 Phone #	24 Fax #	25 E-mail	

Block 3: Funding Year Information

26 Funding Year (Check only one box)	<input type="checkbox"/> Year 2009 (7/1/2009-6/30/2010)	<input type="checkbox"/> Year 2010 (7/1/2010-6/30/2011)
	<input type="checkbox"/> Year 2011 (7/1/2011-6/30/2012)	<input type="checkbox"/> Year 2012 (7/1/2012-6/30/2013)

Block 4: Eligibility

27 Only the following types of HCPs are eligible. Indicate which category describes the applicant. (Check only one.)

<input type="checkbox"/> Post-secondary educational institution offering health care instruction, teaching hospital or medical school	<input type="checkbox"/> Rural health clinic
<input type="checkbox"/> Community health center or health center providing health care to migrants	<input type="checkbox"/> Consortium of the above
<input type="checkbox"/> Local health department or agency	<input type="checkbox"/> Dedicated ER of rural, for-profit hospital
<input type="checkbox"/> Community mental health center	<input type="checkbox"/> Part-time eligible entity
<input type="checkbox"/> Not-for-profit hospital	

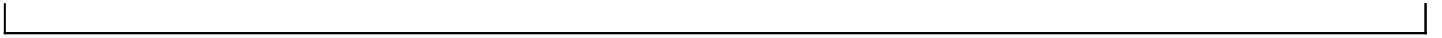
28 If consortium, dedicated emergency department, or part-time eligible entity was selected in Line 27, please describe the entity.

29 Please describe the eligible health care provider's telecommunications and/or Internet service needs, so that service providers may bid to provide the services. The description should describe whether video or store and forward consultations will be used, whether large image files or X-rays will be transmitted, the quality of connection needed, or other relevant considerations.

Block 5: Request for Services

30 Is the HCP requesting reduced rates for:

<input type="checkbox"/> Both Telecommunications & Internet Services	<input type="checkbox"/> Telecommunications Service ONLY	<input type="checkbox"/> Internet Service ONLY
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Block 6: Certification

31 <input type="checkbox"/> I certify that I am authorized to submit this request on behalf of the above-named entity or entities, that I have examined this request, and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
32 <input type="checkbox"/> I certify that the health care provider has followed any applicable State or local procurement rules.	
33 <input type="checkbox"/> I certify that the telecommunications services and/or Internet access charges that the HCP receives at reduced rates as a result of the HCPs' participation in this program, pursuant to 47 U.S.C. Sec. 254 as implemented by the Federal Communications Commission, will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.	
34 <input type="checkbox"/> I certify that the health care provider is a non-profit or public entity.	
35 <input type="checkbox"/> I certify that the health care provider is located in a rural area. Visit the RHCD website: (http://www.usac.org/rhc/tools/rhcdb/Rural/2005/search.asp) or contact RHCD at 1-800-229-5476 for a listing of rural areas.	
36 <input type="checkbox"/> 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 funding provided under 47 U.S.C. Sec. 254.	
37 Signature	38 Date
39 Printed name of authorized person	40 Title or position of authorized person
41 Employer of authorized person	42 Employer's FCC RN

Please remember:

- ◆ Form 465 is the **first** step a health care provider must take in order to receive the benefit of reduced rates resulting from participation in this universal service support program.
- ◆ After the HCP submits a complete and accurate Form 465, the RHCD will post it on the RHCD web site for 28 days.
- ◆ HCPs may not enter into agreements to purchase eligible services from service providers before the **28 days expire**.
- ◆ After the HCP selects a service provider, the HCP must initiate the **next** step in the application process, the filing of Form 466 and/or 466A.

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 purpose of the information is to determine your eligibility for certification as a health care provider. 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 pra@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 Division

30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685
