

**Health Care Providers Universal Service
Funding Request and Certification Form**

466

The Deadline to submit this Form is the June 30th End of the Funding Year.

Estimated time per response: 3 hours

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

7 Contact Name

8 Address Line 1

9 Address Line 2

10 City

11 State

12 Zip

13

16

17 Type of Service & Circuit Bandwidth (Enclose documentation.)

18 Total Billed Miles

19 Maximum Allowable Distance (From Form 465)

20 Percentage of HCP's service used for the provision of health care.

(If less than 100%, please explain.)

If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

21 Service Provider Name

22 Service Provider Number (SPIN)

23 Service Provider Contact Person Name

24 Service Provider Contact Person's Phone#

25 Service Provider Contact Person Email

26 Circuit Start Location

27 Circuit Termination Location

28 Billing Account Number

29 Tariff, Contract or other document reference number

30 Date Contract Signed or Date HCP Selected Carrier

31 Contract Expiration Date (mm/dd/yyyy or NAif MTM)

33 Actual Rural Rate per Month (Enclose Documentation)

34 If you are a consortium member OR have multiple carriers, please attach a Circuit Diagram to show how the sites

interconnect and which carrier(s) provides each circuit segment.

Circuit Diagram included:

Yes

No

35 Are you a mobile rural health care provider? Yes No If yes, see instructions and attach a list of all sites to be served.

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

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 appropriate for the service to transmit the health care services the health care provider

47 Pursuant to 47 C.F.R. Sections 1.101 and 1.102, 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 appropriate for the service to transmit the health care services the health care provider

48 I hereby certify that the billed entity will maintain complete billing records for the service for five years.

49 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 and belief all statements of fact contained herein are true.

50 Signature	51 Date
52 Printed name of authorized person	53 Title or position of authorized person
54 Employer of authorized person	55 Employer's FCC RN

Please remember:

- You must submit one Form 466 for **each service** (i.e., circuit) for which you request reduced rates. For example:
 - If you are requesting reduced rates for **two** T1 lines, you must submit **two** Forms 466.
 - If you are requesting reduced rates for **two** ISDN lines & **one** Frame Relay line, you must submit **three** Forms 466.
- If the service described on this form is subject to the 28-day competitive bidding requirement, do not select a carrier or complete the Form 466 before or during the 28-day posting period.
- You must provide evidence of the urban rate if you have completed Block 6 and have not used the urban rates from the website.
- This form, attachments, and supporting documents should be combined in one envelope and sent to the RHCD.
- If the service described on this form changes (e.g., rate change) during the funding year, you must notify RHCD immediately and submit a revised Form 466.
- If you have any questions, call RHCD at 1-800-229-5476.

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 3 hours 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-PER, 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