



COVID-19 Telehealth Program Application

Filing Instructions

OMB Control No. 3060- 1271

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COVID-19 Telehealth Program Overview

On April 2, 2020, the Federal Communications Commission (FCC) adopted a Report and Order establishing the COVID-19 Telehealth Program. The COVID-19 Telehealth Program will provide \$200 million in funding, appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic. The COVID-19 Telehealth Program will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the program's funds have been expended or the COVID-19 pandemic has ended.

The application for the COVID-19 Telehealth Program, FCC Form 5636, is designed to obtain information from applicants that will be used by the FCC to evaluate and select applications to receive funding. The information is necessary to confirm eligibility, prioritize applications that target areas hardest hit by the COVID-19 pandemic, and determine funding award amounts. Applications will be reviewed as they are received, and funding awards will be made on a rolling basis.

For more information regarding the COVID-19 Telehealth Program, please refer to the COVID-19 Telehealth Program webpage at <https://www.fcc.gov/covid19telehealth>.

For more information regarding the FCC's Coronavirus response, please see: <https://www.fcc.gov/coronavirus>.

Resources for Applicants

Eligibility Determination

For specific questions about eligibility and completing the eligibility form (FCC Form 460), contact USAC via telephone at (800) 453-1546 or via email at: RHC-Assist@usac.org.

CORES (Commission Registration System)

If you need assistance with CORES, please contact the FRN Help Line at 877-480-3201 (M-F 8am-6pm ET) or submit a help request at <https://www.fcc.gov/wireless/available-support-services>.

COVID-19 Telehealth Program

For specific questions about the application, please email TelehealthApplicationSupport@fcc.gov.

For all other questions, please email EmergencyTelehealthSupport@fcc.gov.

I. Who Can Apply?

Health care providers seeking to participate in the COVID-19 Telehealth Program must obtain an eligibility determination from the Universal Service Administrative Company (USAC) for each health care provider site that they include in their application.

Health care provider sites that USAC has already deemed eligible to participate in the Commission's existing Rural Health Care (RHC) Programs may rely on that eligibility determination for the COVID-19 Telehealth Program.

Health Care Provider Sites Without a Current USAC Eligibility Determination:

- Interested health care providers that do not already have an eligibility determination may obtain one by filing an FCC Form 460 (Eligibility and Registration Form) with USAC.
- FCC Form 460 can be filed through [My Portal](https://www.usac.org/rural-health-care/resources/my-portal/) on USAC's website at <https://www.usac.org/rural-health-care/resources/my-portal/>. (Filers do not need to be rural health care providers in order to file Form 460 for this purpose.)
- Applicants that have not yet received an eligibility determination from USAC can still file an application with the Commission for the COVID-19 Telehealth Program while their FCC Form 460 is pending with USAC.
- Consortium applicants may file an FCC Form 460 on behalf of member health care providers if they have a Letter of Agency.
- Contact USAC for specific questions about eligibility and completing the eligibility form (FCC Form 460) via telephone at (800) 453-1546 or email at: RHC-Assist@usac.org.

All applicants to the COVID-19 Telehealth Program must also:

- Obtain an FCC Registration Number (FRN) from the [Commission Registration System \(CORES\)](#), as well as a CORES username and password at that link. An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC and is used to identify the registrant's business dealings with the FCC. For more details on this process, see page 9 of this guide.
- Register with the federal [System for Award Management \(SAM\)](#). For more details on how to register, please see page 26 of this guide.
(While applicants do not need to be registered with the SAM in order to submit an application, they will need to be registered in order to receive funding, and the Bureau strongly encourages applicants to start that process early.)

II. What Must be Submitted?

In order to facilitate the application review process, applicants must complete each section of the application, submit documentation to support the funding requested, and make the required certifications at the end of the application. Specifically, health care providers must submit an application with sufficient information that will allow the Bureau to make selections and funding amount determinations. Please feel free to attach additional pages, as necessary, to respond to the questions on the application. Failure to provide the requested information may result in an application not being selected for funding under the COVID-19 Telehealth Program.

Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in § 0.459 of the Commission's rules.

A. General Information:

- Applicant Information:
 - Applicant Name
 - Applicant FCC Registration Number (FRN)
 - Applicant National Provider Identifier (NPI)
 - Federal Employer Identification Number (EIN/Tax ID)
 - Business Type (from Data Accountability and Transparency (DATA) Act Business Types) – Applicants may provide up to three business types.
 - DATA Act Service Area – This information will be required for each line item for which funding is requested. Applicants must enter name of the applicable state(s) or “nationwide.”

- Contact Information:
 - Contact name for the individual that will be responsible for the application
 - Position title, Company Name
 - Phone number
 - Mailing address
 - Email address

- Health Care Provider (HCP) Information (for each HCP that is part of the application):
 - Health care provider name (if there are multiple HCPs, the first is considered the “lead” HCP)
 - Facility name
 - Indicate whether the facility is a hospital
 - Street address, city, state, county
 - FCC Registration Number (FRN)
 - Healthcare provider number from FCC Form 460
 - Eligibility type
 - National Provider Identifier (NPI)
 - Total patient population

- Estimated number of patients to be served by the funding request (and supporting documentation)

B. Medical Services to be Provided with COVID-19 Telehealth Funding:

- Patient-Based Internet-Connected Remote Monitoring
- Other Monitoring
- Video Consults
- Voice Consults
- Imaging Diagnostics
- Other Diagnostics
- Remote Treatment
- Other services

C. Conditions to be Treated with COVID-19 Telehealth Funding:

- Whether the applicant will treat COVID-19 patients directly
- Whether the applicant will treat patients without COVID-19 symptoms or conditions
- If the applicant will treat patients without COVID-19, identify the types of conditions to be treated or care to be provided (check all that apply):
 - Other infectious diseases
 - Emergency/Urgent Care
 - Routine, Non-Urgent Care
 - Mental Health Services (non-emergency)
 - Other conditions
- How using COVID-19 Telehealth Program funding to treat patients without COVID-19 symptoms or conditions would free up resources that will be used to treat COVID-19

D. Additional Information Concerning Requested Services and Devices

- Goals and objectives for use of the COVID-19 Telehealth Program Funding.
- Timeline for deployment of the proposed service(s) or devices funded by the COVID-19 Telehealth Program.
- Factors/metrics the applicant will use to help measure the impact of the services and devices funded by the COVID-19 Telehealth Program.
- How COVID-19 has affected health care providers in the applicant's area.
- Any additional information about the geographic area and population served by the applicant. Indicate whether the geographic area served has been under any pre-existing strain (e.g., large underserved or low-income patient population; HCP shortages; rural hospital closures; limited broadband access and/or Internet adoption). If so, describe such factors.
- Whether the applicant plans to target the funding to high-risk and vulnerable patients. If so, describe how.
- Any additional information to support the application and request for funding.

E. Requesting Funding Items

- Total amount of funding requested
- Whether funding for devices is being requested. If so:
 - How are the devices integral to patient care?
 - Are the devices for patient use?
 - Are the devices for the health care provider's use?

F. Supporting Documentation

Applicants should provide supporting cost documentation (e.g., an invoice or a vendor quote) for all eligible services and devices for which funding is requested. The detailed line item information that is strongly encouraged for all eligible services and devices for which funding is requested includes:

- Category
- Description of service(s) and/or device(s)
- Quantities of services or devices
- Total one-time expense
- Total monthly expense
- Expense date purchased or to be purchased
- Service dates for recurring services

III. When to Apply

Applications may be submitted through the FCC’s COVID-19 Telehealth online portal, accessible at <https://www.fcc.gov/covid19telehealth>. Funding determinations will be made on a rolling basis until program’s funds have been expended or the COVID-19 pandemic has ended.

IV. How to Apply

Applications may be submitted through the FCC’s COVID-19 Telehealth online portal, accessible at <https://www.fcc.gov/covid19telehealth>. Applicants who have already started filling out the PDF form may submit their applications to TelehealthApplicationSupport@fcc.gov.

The Commission’s hand-delivery filing location is closed and cannot be used to submit applications for the COVID-19 Telehealth Program. A copy of each completed application filed will be automatically filed in ECFS at a later date. Confidential information **should not** be included on the application form itself. Any confidential information for an application should be submitted as an attachment. Applicants will have an opportunity to request confidential treatment for confidential information included an attachment. This option is located on the Purpose and Intent tab.

1. Obtain an FCC Registration Number (FRN)

All applicants, like all other entities doing business with the Commission, must register for an FRN in the Commission Registration System (CORES). An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC. This unique FRN is used to identify the registrant’s business dealings with the FCC.

To register with CORES, please use the following link:

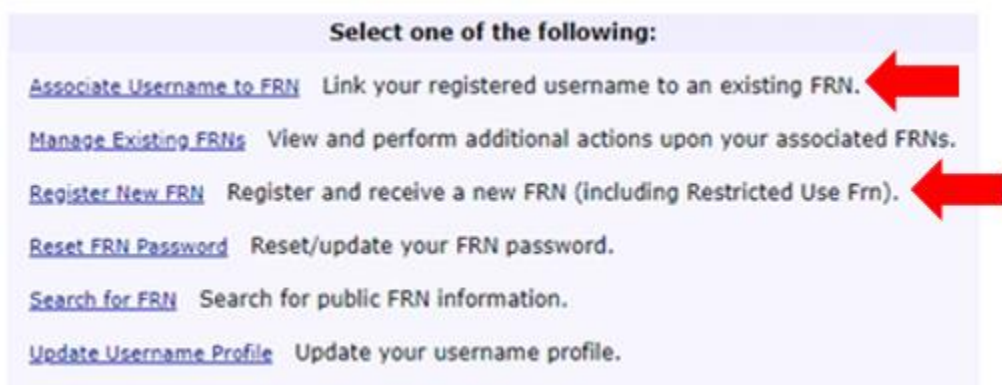
<https://apps.fcc.gov/cores/userLogin.do>



The first step to setting up an account in CORES is creating a username and account in the FCC User Registration System. Before the account is activated, the user will receive an

automated email titled “FCC Account Request Verification” and must verify its account email address as prompted.

Once the user is logged in to CORES, the user should select the “Register New FRN” or “Associate Username to FRN” option as applicable from the menu options that appear and provide the information as prompted by CORES.



Users will need to provide their taxpayer identification number or TIN to register. The TIN is a nine-digit number that the Internal Revenue Service (IRS) requires of all individuals, businesses, and other employers to identify their tax accounts with the IRS. Once the user provides the information required in CORES and clicks “Submit,” CORES will generate a new FRN or associate the user’s existing FRN with its account.

2. Sign In and Start a New Form:

Navigate to <https://www.fcc.gov/covid19telehealth> and select “Submit an Application Online.” You will then be directed to a log in screen. Log into the system using your CORES username and password:

A screenshot of the FCC Sign In page. At the top left is the FCC logo (the letters "FC" in a circle) and the text "Federal Communications Commission". Below the logo is the heading "Sign In". There are two input fields: "Username" with a person icon and "Password" with a lock icon. Below the password field is a "Remember me" checkbox. A blue "Sign In" button is centered below the checkbox. At the bottom left, there is a link that says "Need help signing in?".

If you have not created a CORES username and password, you must do so through the FCC’s CORES webpage at <https://apps.fcc.gov/cores/userLogin.do>.

After you log in, you will be directed to the COVID-19 Telehealth program landing page, shown below. To initiate an application, click the “[Start a New Application](#)” button.

COVID-19 Telehealth Program Application

Information on the COVID-19 Telehealth Program and how to file an application can be found here:

- [Filing Instructions \(PDF\)](#)
- [FCC COVID-19 Telehealth Program webpage](#)

In order to file an application, each applicant must obtain an FCC Registration Number (FRN) from Commission Registration System (CORES).

In addition to filing an application here, each applicant must do the following as part of the application process:

- 1) Obtain an eligibility determination from the Universal Service Administrative Company (USAC) by filing FCC Form 460 through My Portal on USAC's webpage.
- 2) Register with the federal System for Award Management (SAM)

If you have questions, please email TelehealthApplicationSupport@fcc.gov.

OMB Control Number: 3060-1271

[Start a New Application](#) →

Telehealth Applications

In progress **2** Need More Information **0** Submitted **1** Commitment Completed **0**

☰ In progress

Tips for Navigating the Application:

1. Fully and accurately complete all fields on the form marked with an asterisk (*). These fields are required and you must answer them for your application to be complete. Required fields are also noted in the instructions.
2. To answer questions that require a more detailed response, consider drafting your response in a separate document and then copying and pasting that response into your application.
3. Save the form often to preserve your work; we recommend that you fully complete each section and then save that section by clicking save at the bottom of the page before moving to a new section.

3. Enter Applicant Information

The unpopulated form shown below should appear:

After entering Application Contact Information, please click the "Save Draft" button. Then you will be able enter information for the health care providers (HCPs) associated with this application. ✕

Telehealth Application - new record 📎

Note: The following read-only fields are automatically updated or populated by the system.

Number: GRA0000122 State: In Progress

Status: Pending

Applicant information

* Applicant: Joanna Fister

* Applicant FCC Registration Number (FRN) Applicant National Provider Identifier (NPI)

* Federal Employer Identification Number (EIN or TAX ID Number)

* Data Universal Numbering System (DUNS) Number

* DATA Act Business Types

* Service Area: -- None --

Contact Information Services and Conditions Purpose and Intent Funding Request Certification

Please Note: A consortium filing for multiple health care providers should use the information of the lead entity for this section.

- **Applicant FCC Registration Number (FRN)** – Select your FCC Registration Number from the drop-down menu in the box labeled FRN by typing the first few numbers. This field is required.
- **Applicant National Provider Identifier (NPI)** – Enter your 10-digit NPI obtained from the National Plan and Provider Enumeration System. This field is optional.
- **Federal Employer Identification Number (EIN or TAX ID Number)** – Enter your EIN or Tax ID number. This field is required.
- **Data Universal Number System (DUNS) Number** – Enter your unique business identifier. This information is required by the 2014 Digital Accountability and Transparency Act (DATA Act). This field is required.
- **Enter DATA Act Business Types**
From the dropdown menu, choose three Business Types that best describe the organization. These selections will be reported as part of the DATA Act and are required.

Below is a list of the different Business Types and their description:

Code	Code Label	Code Description
A	State Government	The recipient is a U.S. state government.
B	County Government	The recipient is a U.S. county government.
C	City or Township government	The recipient is a U.S. city or township government
D	Special District Government	The recipient is a special district government.
E	Regional Organization	The recipient is a U.S. regional organization.
F	U.S. Territory or Possession	The recipient is a U.S. territory or possession.
G	Independent School District	The recipient is a U.S. independent school district.
H	Public/State Controlled Institution of Higher Education	The recipient is a U.S. Public/State Controlled Institution of Higher Education
I	Indian/Native American Tribal Government (Federally - Recognized)	The recipient is an Indian/Native American Tribal Government (Federally Recognized)
J	Indian/Native American Tribal Government (Other than Federally-Recognized)	The recipient is an Indian/Native American Tribal Government (Other than Federally Recognized)
K	Indian/Native American Tribal Designated Organization	The recipient is an Indian/Native American Tribal Designated Organization
L	Public/Indian Housing Authority	The recipient is a Public/Indian Housing Authority
M	Nonprofit with 501C3 IRS Status (Other than an Institution of Higher Education)	The recipient is a Nonprofit with 501C3 IRS Status (Other than an Institution of Higher Education)
N	Nonprofit without 501C3 IRS Status (Other than an Institution of Higher Education)	The recipient is a Nonprofit without 501C3 IRS Status (Other than an Institution of Higher Education)
O	Private Institution of Higher Education	The recipient is a Private Institution of Higher Education
P	Individual	The recipient is an Individual
Q	For-Profit Organization (Other than Small Business)	The recipient is a For-Profit Organization (Other than Small Business)
R	Small Business	The recipient is a Small Business
S	Hispanic-serving Institution	The recipient is an Hispanic-serving Institution
T	Historically Black College or University (HBCU).	The recipient is a Historically Black College and University (HBCUs)
U	Tribally Controlled College or University (TCCU)	The recipient is a Tribally Controlled College or University (TCCUs)
V	Alaska Native and Native Hawaiian Serving Institutions	The recipient is an Alaska Native and Native Hawaiian Serving Institutions
W	Non-domestic (non-U.S.) Entity	The recipient is a Non-domestic (non-U.S.) Entity
X	Other	The recipient is not covered under any of the other categories above

- **Service Area** – Enter the state where applicant provides service or select “nationwide.”

Data Act Disclosure - The Name, Address, DUNS Number and Business Type will be disclosed in accordance with Federal Funding Accountability and Transparency Act of 2006 (FFATA)/DATA Act reporting requirements.

4. Enter Contact Information

You will then see a tab asking for additional information regarding your contact information, shown below:

The screenshot shows a web application interface with a horizontal tabbed menu at the top. The tabs are: 'Contact Information', 'Terms and Conditions', 'Purpose and Intent', 'Funding Request', and 'Certification'. The 'Contact Information' tab is highlighted with a red circle and a red arrow pointing to it from the left. Below the tabs, the form contains several input fields, each with a red asterisk indicating it is required:

- * Contact Name: A text input field.
- * Position Title: A text input field.
- Mailing Address: A section header followed by four input fields:
 - * Street: A text input field.
 - * City: A text input field.
 - * State: A dropdown menu.
 - * Zip: A text input field.
- * Email: A text input field.
- * Phone: A text input field.

At the bottom of the form is a blue button labeled 'Save Draft'.

- **Contact Name** – Enter the name of the contact person for the application.
- **Position Title, Company Name** – Enter the position title of the contact person for the application and their company name.
- **Email** – Enter the email address of the contact person for the application.
- **Phone** – Enter the phone number of the contact person for the application.
- **Mailing Address** – Enter the street, city, state, and zip code of the contact person for the application.

After entering Application Contact Information, please click the 'Save Draft' button. Then you will be able to enter information for the health care providers associated with this application.

Mailing Address

* Street

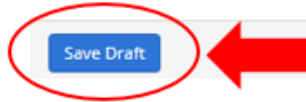
* City

* State

* Zip


* Email

* Phone

Save Draft 

After clicking "Save Draft" button, the Health Care Provider tab will appear, as shown below. Click "New" to enter the Health Care Provider Information.

Health Care Provider Funding Request


Health Care Provider **New** 

No records in Health Care Provider using that filter

5. Enter Health Care Provider (HCP) Information

Upon clicking “New,” you will then be directed to an unpopulated form shown below:

Health Care Provider	
Number HCP0000082	Associated Application
* Facility Name	* FRN
* Is Lead HCP? -- None --	HCP Number
* Street Address	Eligibility Type -- None --
* City	NPI
* State	
* County in which address is located	
* Is the Facility a Hospital? -- None --	
* Total Patient Population	
Estimated Number of Patients to be Served by Funding Request	

 Close Add

Please Note: A consortium filing for multiple health care provider sites must fill out a new health care provider tab for each site it is filing on behalf of.

- **Facility Name** – Enter the health care provider facility name or name of lead entity for a consortium. This field is required.
- **FRN** – Enter the FCC Registration Number for each health care provider (or entity). This field is required.
- **Is Lead HCP** – Select “yes” if this provider (or entity) is the lead for the application. Select “no” for all additional health care provider site. This field is required.
- **HCP Number** – Enter the HCP Number assigned from FCC Form 460. This field is optional.

- **Eligibility Type** – Enter the eligibility type selected on your FCC Form 460. This field is optional. Health Care Provider Eligibility Types eligible for funding under the COVID-19 Telehealth Program include:
 - (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools
 - (2) community health centers or health centers providing health care to migrants
 - (3) local health departments or agencies
 - (4) community mental health centers
 - (5) not-for-profit hospitals
 - (6) for-profit dedicated emergency rooms
 - (7) health clinics
 - (8) skilled nursing facilities
 - (9) consortia of health care providers consisting of one or more entities falling in categories (1)-(8)

- **Address** – Entering the street address, city, and state where the health care provider (or entity) is located. This field is required.
- **NPI** – Enter the 10-digit NPI obtained from the National Plan and Provider Enumeration System for the health care provider. This field is optional.
- **County** – Enter the county where the health care provider is located. This field is required.
- **Is the Facility a Hospital?** – Select “yes” if this provider is a hospital; otherwise select “no.” This field is required.
- **Total Patient Population** – Enter the number of patients each health care provider site treats each year. This field is required. Applicants are encouraged to provide additional explanation or supporting documentation as an attachment.
- **Estimated Number of Patients to be Served** – Enter the total estimate of patients that will be served with the funds requested. This field is required. Applicants are encouraged to provide additional explanation or supporting documentation.

Application Tip: Be sure to click “Save” after completing the HCP tab.

6. Enter Services and Conditions

You will then see a tab asking for additional information on services and conditions, shown below:

The screenshot shows a web application interface with a navigation bar at the top containing five tabs: 'Contact Information', 'Services and Conditions', 'and Intent', 'Funding Request', and 'Certification'. The 'Services and Conditions' tab is circled in red, and a red arrow points to it from the right. Below the navigation bar, the form is titled 'Medical Services To Be Provided with COVID-19 Telehealth Funding (check all that apply):'. It lists several services with checkboxes: Patient-Based Internet-Connected Remote Monitoring, Other Monitoring, Video Consults, Voice Consults, Imaging Diagnostics, Other Diagnostics, Remote Treatment, and Other services. Below this list is a text box for 'Additional Information on Medical Services to be Provided'. The next section is 'Conditions To Be Treated with COVID-19 Telehealth Funding', which includes two dropdown menus: 'Would you treat COVID-19 patients directly?' and 'Would you treat patients without COVID-19 symptoms or conditions?'. Below these are instructions and a list of conditions with checkboxes: Emergency / Urgent Care, Mental Health Services (non-emergency), Other Infectious diseases, Routine, Non-Urgent Care, and Other conditions (explain below). A text box for 'if you will treat patients without COVID-19, explain...' follows. At the bottom, there is a text box for 'Additional Information on Specific Conditions to be Treated:' and a blue 'Save Draft' button.

- **Medical Services to be Provided with COVID-19 Telehealth Funding** – Check all medical services that the health care provider sites in the application plan to provide with requested funding. You are encouraged to provide additional explanation in the text box.
- **Conditions to be Treated with COVID-19 Telehealth Funding** – Identify whether you plan to treat patients with COVID-19 or other patients to free up resources. If you answer “yes” to treating patients without COVID-19 symptoms, you must select which conditions you will treat and explain how using this funding will free up resources to treat COVID-19. You are encouraged to provide additional explanation in the text box.

7. Purpose and Intent

You will then see a tab asking for additional information on your purpose and intent for the requested funding, shown below:

Contact Information Services and Conditions **Purpose and Intent** Funding Request Certification

*What are your goals and objectives for use of the COVID-19 Telehealth Funding?

*What is your timeline for deployment of the proposed service(s)?

*What metrics will you use to help measure the impact of the funds used?

How has COVID-19 affected HCPs in your geographic area (e.g. county)?

Have you been under pre-existing strains? If so, please describe such factors.

*Do you plan to target the funding to high-risk and vulnerable patients?

Note: If "Yes", applicant must populate or complete the "If so, please describe how." field below.
If so, please describe how.

Please provide any additional information to support your application and

Do you request confidential treatment of supporting documentation?

[Save Draft](#)

- **What are your goals and objectives for use of the COVID-19 Telehealth Program Funding** – Please explain what you aim to accomplish with the funding requested. This question is required.
- **What is your timeline for deployment of the proposed service(s) or devices funded by the COVID-19 Telehealth Program?** – Please explain the timing of purchase and deployment for the service(s) and devices you are requesting funding for. This question is required.
- **What factors/metrics will you use to help measure the impact of the services and devices funded by the COVID-19 Telehealth Program?** – Please explain what factors and/or metrics you intend to use to measure the impact of the services and devices funded by the program. This question is required.

- **Please provide additional information about the geographic area and population you serve.** – Please explain if your area has any pre-existing strain factors, such as a large underserved or low-income patient population, recent health care provider closures or other deficiencies. This question is optional.
- **Do you plan to target the funding to high-risk and vulnerable patients?** -- Please choose from the drop down either “yes” or “no.” This question is required.
- **Additional Information for Targeting High Risk Patients** -- If applicable, please elaborate on how you plan to target high risk patients with additional funding. This question is optional.

8. Confidentiality

By designating supporting documents and information as “Confidential,” the applicant is deemed to have submitted a request that the material be withheld from public inspection pursuant to 47 CFR § 0.459. Applicants designating documents as “Confidential” should not submit those documents in the FCC’s Electronic Comment Filing System.

To request confidential treatment of supporting documentation, answer “Yes” to the question on the bottom of the Purposes and Intent tab. Confidential information **should not** be included on the application form itself. Any confidential information should be submitted as an attachment.

9. Funding Requested

You will then see a tab asking for additional information on your funding request, shown below:

The screenshot shows a navigation bar with five tabs: 'Contact Information', 'Services and Conditions', 'Purpose and Intent', 'Funding Request', and 'Certification'. The 'Funding Request' tab is circled in red, and a red arrow points to it from the right. Below the tabs, there is a note: 'Note: The Commission does not anticipate awarding more than \$1 million to any single applicant.' followed by a red asterisk and the text '* Total Amount of Funding Requested' above a text input field. Below that is another red asterisk and the text '* Are you requesting funding for devices?' above a dropdown menu with '-- None --' selected. At the bottom left of the form area is a blue 'Save Draft' button.

- **Please note:** Applicants can only seek funding for (a) Internet/broadband or voice connectivity services and (b) devices that are connected to the internet or a broadband/voice network and used for patient care, monitoring, treatment, or diagnostics

- **Examples of services and devices that COVID-19 Telehealth Program applicants may seek funding for include:**
 - Telecommunications Services and: Voice service .
 - Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
 - Internet Connected Devices/Equipment: tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband enabled blood pressure monitors; pulse-ox; etc.) for patient or health care provider use; telemedicine kiosks/carts for health care provider site.

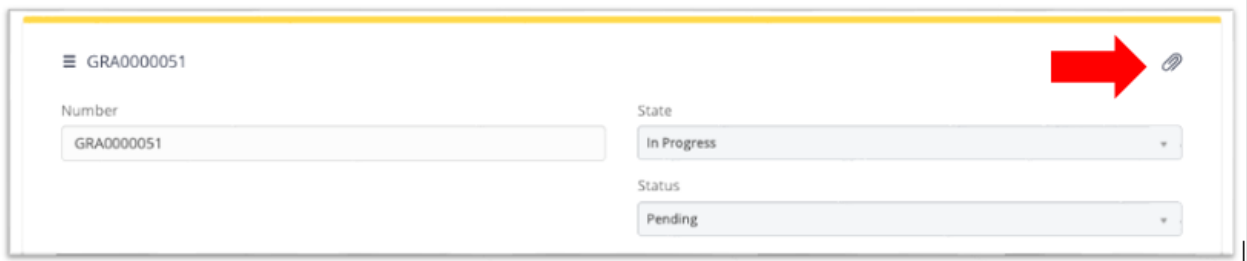
- **Total amount of funding requested** – Please enter the total amount of funding in a dollar amount; please note that we do not anticipate awarding more than \$1 million in funding to any one applicant. This question is required.
- **Are you requesting funding for devices** – Please choose from the drop down either “yes” or “no.” This question is required.
- **How are devices integral to patient care** – Please explain how these devices are necessary to provide care to your patient population. This question is required if you are requesting funding for devices.
- **Are the devices for patient use** -- Please choose from the drop down either “yes” or “no.” This question is required if you are requesting funding for devices.
- **Are the devices for the health care provider’s use** -- Please choose from the drop down either “yes” or “no.” This question is required if you are requesting funding for devices.

10. Supporting Documentation

An applicant should provide supporting documentation for the costs indicated in its application. Such supporting documentation should summarize the expected costs of the eligible services and devices requested and may include documentation such as an invoice or quote from a vendor or service provider (or similar information). Such information should be specific enough to identify line-items to facilitate swift review of the application, and we encourage applicants to include information such as a description of the service or device, its eligibility category, the quantity ordered, the upfront and monthly expenses, and the service dates for recurring services.

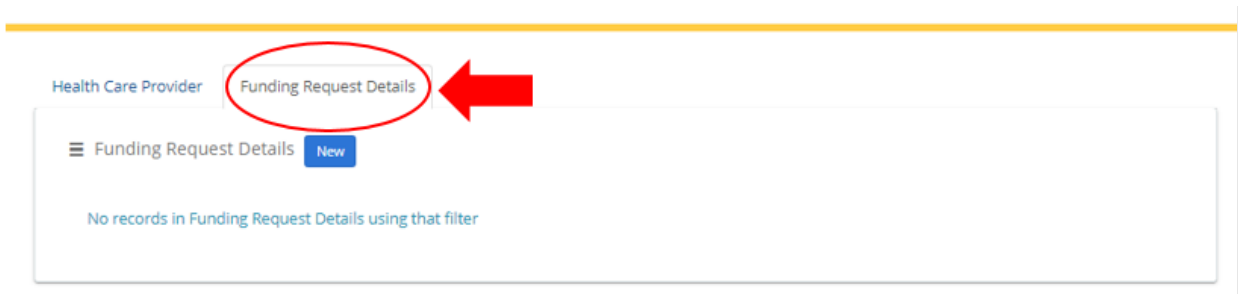
Note: Supporting Cost Documentation is required material.

Supporting documentation can be attached at the top of the application, as shown below:



The screenshot shows the top section of an application form. On the left, there is a menu icon followed by the application number "GRA0000051". Below this, there are two input fields: "Number" with the value "GRA0000051" and "State" with a dropdown menu showing "In Progress". To the right of the "State" field, there is a "Status" dropdown menu showing "Pending". A red arrow points to a small paperclip icon in the top right corner, indicating where to attach supporting documentation.

Applicants may also provide additional detail for the funding request in the funding request details table at the bottom of the page. Switch to the Funding Request Details tab, as shown below. Click “New” to enter these details.



The screenshot shows the application interface with the "Funding Request Details" tab selected and circled in red. A red arrow points to the "Funding Request Details" tab. Below the tabs, there is a "New" button. The main content area shows "No records in Funding Request Details using that filter".

Upon clicking “New,” you will then be directed to an unpopulated form shown below:

Add Row



Funding Request Details

Number

FDR0000153

Associated Application

Category

-- None --

Description of Service(s) and/or Device(s)

Quantities(For Devices)

Total One-Time Expense

\$ 0.00

Total Monthly Expense

\$ 0.00

Number of Months for Recurring Monthly Expenses

Date [Purchased or] To Be Purchased



Close

Add

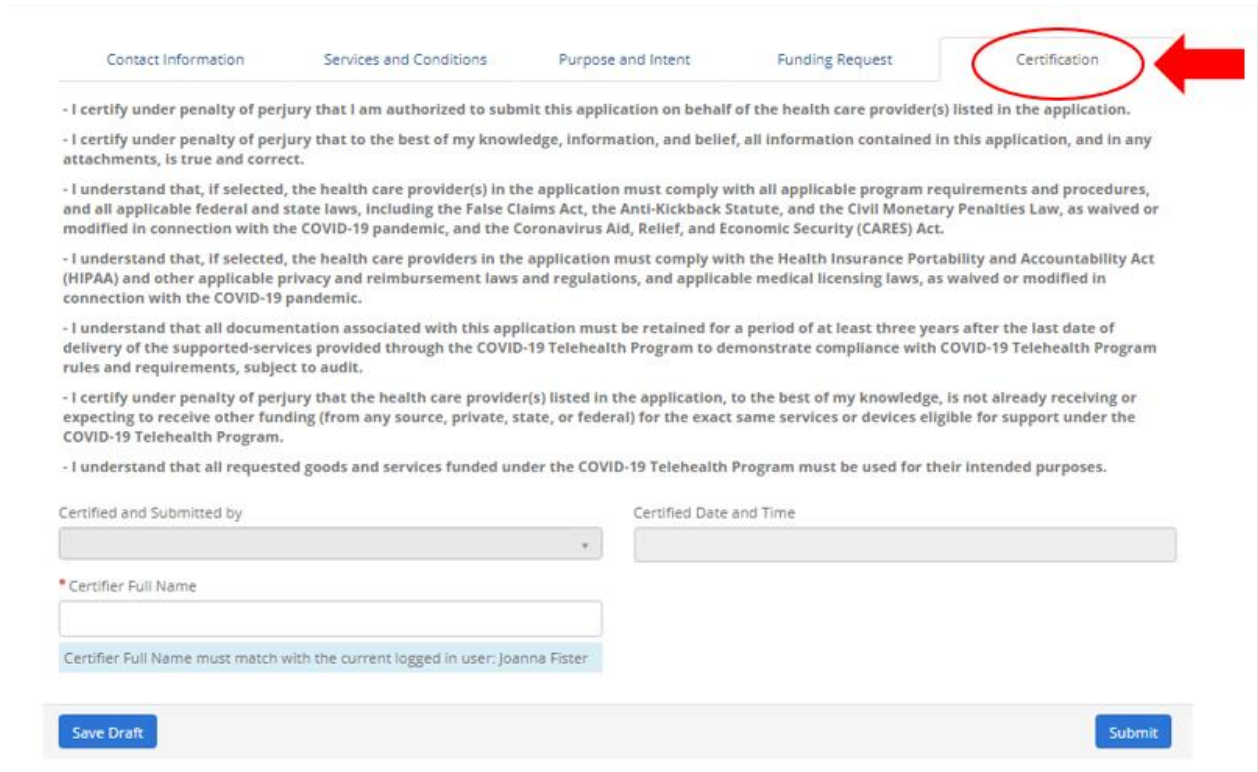
- **Category** – Please select the category that best fits the line item. This field is optional.
- **Description of Service(s) and/or Device(s)** – Please briefly describe the line item service or device(s) on the funding request. This field is optional.
- **Quantities (for devices)** – Please enter the line item quantity for devices.
- **Total One-Time Expense** – Please enter the total one-time expense associated with the line item. This field is optional.
- **Total Monthly Expense** – Please enter the total monthly expense associated with the line item. This field is optional.
- **Date** – Please enter the date the line service or device(s) were purchased or the date to be purchased. This field is optional.
- **Number of Months for Recurring Service** – Please enter the total number of months for the line item. This field is optional.

Applicants can optionally create a new item in the funding request details table for each line item.

Application Tip: Be sure to click “Save” after completing the Funding Request Details tab.

11. Certify & Submit

When you are ready to submit the information, please click the “Submit” button on the certifications tab. Carefully read the language that appears in the Certify Submission pop-up window and click then click “Certify & Submit” button. See Certification below for more information.



The screenshot shows the 'Certification' tab selected in a navigation bar. A red circle highlights the 'Certification' tab, and a red arrow points to it from the right. Below the navigation bar, there are several lines of text, each preceded by a hyphen, representing the certification statements. At the bottom of the form, there are two input fields: 'Certified and Submitted by' and 'Certified Date and Time'. Below these is a text input field for 'Certifier Full Name' with a red asterisk indicating it is required. A blue tooltip below the name field states: 'Certifier Full Name must match with the current logged in user: Joanna Fister'. At the bottom of the form, there are two buttons: 'Save Draft' and 'Submit'.

You will then see a confirmation of submission in green, shown below:



The screenshot shows a confirmation message in a green box. The message reads: 'You've successfully submitted Telehealth Application - GRA0000045. You can find this record later by navigating to the list below under the "Submitted" tab.' A red arrow points to the right side of the green box. Below the green box, there is a section titled 'COVID-19 Telehealth Program Application'. Underneath, there is a link to 'Information on the COVID-19 Telehealth Program and how to file an application can be found here:' followed by three bullet points: 'Filing Instructions (PDF) KB00029282', 'FCC COVID-19 Telehealth Program webpage fcc.gov/covid19telehealth', and 'Guidance on the Application Process'. Below the bullet points, there is a line of text: 'If you have questions, please email EmergencyTelehealthSupport@fcc.gov.' At the bottom, there is a line of text: 'In order to file, each applicant must obtain an FCC Registration Number (FRN) from Commission Registration System (CORES), as well as a CORES username and password, which can also be obtained at that link.' Below this, there is a line of text: 'OMB Control Number: 3060-1271'. At the bottom of the page, there is a blue button that says 'Start a New Application'.

12. Revise an Application In Progress

Once you have saved a draft of a filing or submitted a filing, the filing will be listed under Telehealth Applications on the Covid-19 Telehealth Program landing page, below the “Start a New Form” button.

- **In Progress Status**

Applications that have been saved but not submitted will have a Status of “In Progress.” If you click on the application listed in the table, you can return to the submission form to add to or change the information entered, and then click Save or Certify & Submit.

- **Submitted Status**

Applications that have been certified and submitted (see Step 11 above) will have a Status of “Submitted” in the Telehealth Applications table. If you click on the link to a Submitted filing, you will be able to view the information you submitted for that filing.

- **Needs More Information Status**

If your application needs additional information, application reviewers will contact you. You will then have the opportunity to revise your application and provide additional supporting documentation.

13. Final Steps:

Registering with System for Award Management:

To receive payments through the COVID-19 Telehealth Program, applicants must be registered with the federal System for Award Management. The System for Award Management is a web-based, government-wide application that collects, validates, stores, and disseminates business information about the federal government's partners in support of federal awards, grants, and electronic payment processes. Many applicants may already be registered with the System for Award Management and do not need to re-register with that system in order to receive payment through the COVID-19 Telehealth Program.

Health care providers not yet registered with the System for Award Management may still submit an application. However, it is strongly recommended that unregistered health care providers start that registration process now because it may take up to 10 business days for your registration to become active and an additional 24 hours before that registration information is available in other government systems.

To register with the system:

Go to <https://www.sam.gov/SAM/> with the following information:

- (1) DUNS number;
- (2) Taxpayer Identification Number (TIN) or Employment Identification Number (EIN); and
- (3) Your bank's routing number, your bank account number, and your bank account type, i.e. checking or savings, to set up Electronic Funds Transfer (EFT).

You will receive a confirmation email once the registration is activated. **Only applicants registered through the System for Award Management will be able to receive COVID-19 Telehealth Program funding.**

CARES Act Reporting Requirements

As part of this information collection and not later than 10 days after the end of each calendar quarter, each entity recipient that receives COVID-19 Telehealth Program funds that amount to more than \$150,000 must submit to the FCC and the Pandemic Response Accountability Committee a report that contains—(A) the total amount of large covered funds received from the agency; (B) the amount of large covered funds received that were expended or obligated for each project or activity; (C) a detailed list of all projects or activities for which large covered funds were expended or obligated, including—(i) the name of the project or activity; (ii) a description of the project or activity; and (iii) the estimated number of jobs created or retained by the project or activity, where applicable; and (D) detailed information on any level of subcontracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the Federal Funding Accountability and Transparency Act of 2006 (FFATA) (31 U.S.C. 6101 note) allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget. Not later than 30 days after the end of each calendar quarter, the Committee, in consultation with the FCC will make this information publicly available by posting the information on the website established under section 15010(g).