

**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.**

1 HCP Name <b>ABC Health Care</b>		2 HCP Number <b>12345</b>	
3 Form 465 Application #	4 Consortium Name (If any) <b>RHC East</b>		
5 Billed Entity Name <b>RHC East</b>		6 Billed Entity FCC RN <b>2345678912</b>	
7 Contact Name <b>John Doe</b>			
8 Address Line 1 <b>9 College Avenue</b>			
9 Address Line 2			
10 City <b>Phoenix</b>		11 State <b>AZ</b>	12 Zip <b>85086</b>
13 Contact Phone <b>(888)888-8888</b>	14 Fax # <b>(888)888-8888</b>	15 E-Mail <b>JohnDoe@net.com</b>	

16 Funding Year - Check only one box  
 Year 2005 (7/1/2005-6/30/2006)    
 Year 2006 (7/1/2006-6/30/2007)    
 Year 2007 (7/1/2007-6/30/2008)

17 Type of Service & Circuit Bandwidth (Enclose documentation.) **T-1, 1.544**

18 Total Billed Miles **50**     19 Maximum Allowable Distance (From Form 465) **100**

20 Percentage of HCP's service used for the provision of health care. **100%** (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.

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Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name	<b>Smith Telco</b>			
22 Service Provider Identification Number (SPIN)	<b>143004567</b>			
23 Service Provider Contact Person Name	<b>Joe Green</b>			
24 Service Provider Contact Person's Phone #	<b>(888)888-8888</b>			
25 Service Provider Contact Person Email	<b>Joe@net.com</b>			
26 Circuit Start Location	<b>Window Rock, AZ</b>			
27 Circuit Termination Location	<b>Tucson, AZ</b>			
28 Billing Account Number	<b>589764</b>			
29 Tariff, Contract, or other document reference number	<b>Tariff</b>			
30 Date Contract Signed or Date HCP Selected Carrier	<b>7/1/2005</b>			
31 Contract Expiration Date (mm/dd/yyyy or "T")	<b>T</b>			
32 Service Installation Date	<b>7/1/2005</b>			
33 Actual Rural Rate per Month (Enclose Documentation)	<b>\$ 450.00</b>			
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: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> 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.**

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may need to ask your service provider representative to provide this information.

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

**If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)**

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary for the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)				
40 One-time Rural Rate Charge (in city where HCP is located)				
41 Monthly Urban Rate (in selected large city). From RHCD web site: <input checked="" type="checkbox"/> or Other rate documentation attached: <input type="checkbox"/>	\$240.00			

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to Block 7.

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website?  Yes  No  
If you checked yes, copies of the bids MUST be mailed to RHCD.

46  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 necessary for the service to adequately transmit the health care services required by the health care provider.

47  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 universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.

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, information, and belief, all statements of fact contained herein are true.

50 Signature	51 Date	7/30/2005
52 Printed name of authorized person <b>John Smith</b>	53 Title or position of authorized person	<b>Director</b>
54 Employer of authorized person <b>RHC East</b>	55 Employer's FCC RN	<b>1234567891</b>