FCC Form **462**

OMB Approved 3060-0804
Estimated Time Per Response: 2 hours

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Funding Request Form

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

Block 1: General Information	
1 Funding Year _____	2 Funding Request Number (FRN):
3 HCP Number:	4 Site Name/Consortium Name:

Block 2: Competitive Bidding Information		
5 FCC Form 461 Application Number:		
6 Allowable Contract Selection Date (ACSD):		
7 Number of vendors who bid:		
8 Request for competitive bidding exemption (Only complete if claiming a competitive bidding exemption).		
☐ Annual Undiscounted Cost of $10,000 or less		
☐ Government Master Services Agreement	Contract ID:	Friendly Name:
☐ Pre-Approved Master Services Agreement	Contract ID:	Friendly Name:
☐ Evergreen Contract	Contract ID:	Friendly Name:
☐ E-Rate Approved Contract	Contract ID:	Friendly Name:

Block 3: Vendor Information
9 Service provider identification number (SPIN):
10 Vendor name:

Block 4: Type of Funding Request
11 ☐ Individual HCP, single eligible expense ☐ Individual HCP, multiple eligible expenses ☐ Consortium Application

Block 5: Single Eligible Expense Request for Funding	
12 Category of Expense	13 Expense Type
14 Bandwidth	14a Is this service symmetrical? ○ Yes ○ No If no, what is the upload bandwidth _____. What is the download bandwidth _____.
15 Circuit ID (optional)	
16 Percentage of expense eligible	
17 Does the Service Type include both eligible and ineligible components? ○ Yes ○ No If yes, percentage of usage eligible _____	
18 Billing Account Number (BAN)	
19 Contract ID	19a Date contract signed
19b Expected service start date	19c Length of initial contract term
19d Number of contract extensions	19e Length of optional extension(s) combined
20 Circuit start location	21 Circuit end location
22 Is this a multi-year funding request? ○ Yes ○ No	Multi-year commitments cannot exceed 3 funding years and may not extend beyond the expiration date of an Evergreen Contract.
23 Expense frequency	24 Quantity of expense periods
25 Undiscounted cost per expense period	26 Source of HCP contribution
27 One-time installation charges	

28 This contract contains a Service Level Agreement. ○ Yes ○ No		
If yes, provide the following information concerning the SLA in the contract:	a. Latency:	b. Jitter:
	c. Packet Loss:	d. Reliability:

Block 6: Multiple Eligible Expenses and Consortium Requests for Funding (attach Network Cost Worksheet)

29 Total undiscounted cost for eligible recurring expenses	
30 Total undiscounted cost for eligible non-recurring expenses	

Block 7: Additional Documentation

31 List all supporting documentation (Competitive bids, Contract, etc.) that is required to be submitted with this form.

Type of Documentation
a.
b.
c.

Block 8: Request for Confidentiality

32 Is applicant requesting confidential treatment and non-disclosure of commercial and financial information? (See instructions for specific information covered by this request.) ○ Yes ○ No

Block 9: Certifications

33 ☐	I certify that I am authorized to submit this request on behalf of the health care provider or consortium.
34 ☐	I declare under penalty of perjury that I have examined this form and attachments and to the best of my knowledge, information, and belief, all information contained in this form and in any attachments is true and correct.
35 ☐	I certify under penalty of perjury that the health care provider or consortium has considered all bids received and selected the most cost-effective method of providing the requested services. The "most cost-effective service" is defined as the "method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services." 47 C.F.R. Sec. 54.642(c).
36 ☐	I certify under penalty of perjury that all Healthcare Connect Fund support will be used only for the eligible program purposes for which support is intended.
37 ☐	I certify that the health care provider or consortium is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.
38 ☐	I certify that the health care provider or consortium satisfies all of the requirements under Section 254 of the Telecommunications Act of 1996, as amended, and applicable Commission rules, and understand that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to recission.
39 ☐	I certify that I have reviewed all applicable requirements for the program and will comply with those requirements.
40 ☐	I understand that all documentation associated with this application, including all bids, contracts, scoring matrices, and other information associated with the competitive bidding process, and all billing records for services received, must be retained for a period of at least five years pursuant to 47 C.F.R. § 54.648, or as otherwise prescribed by the Commission's rules.

41 Signature	42 Date
43 Printed Name of Authorized Person	
44 Title/Position of Authorized Person	
45 Phone Ext.	46 Email
47 Employer	48 Employer's FCC RN

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 2 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-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 PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Network Cost Worksheet (attach, if required, to Form 462)

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	Site Information		Contract Information						Eligible Expense Information								Quality of Service Guarantees (if applicable and available)				
	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U
Line Number	HCP Number	Site Name	Contract ID	Contract Friendly Name	Date Contract Signed/Vendor Selected	Length of initial contract term	Number of contract extensions	Length of optional extension(s) combined	Billing Account Number	Category of Expense	Expense Type	Explanation of Eligible Expense	Is this Service Symmetrical?	Upload Speed	Download Speed	Expected Broadband Service Start date/Shipping Date/Last Day of Work	Service Level Agreement	Latency	Jitter	Packet Loss	Reliability
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Line Number (continued)	Circuit Information (if applicable)					Financial Information								
	V	W	X	Y	Z	AA	AB	AC	AD	AE	AF	AG	AH	AI
	Circuit ID (if available)	Circuit Start Location (if applicable)	Circuit End Location (if applicable)	Total Number of Fiber Strands (if applicable)	Number of Fiber Strands Eligible for Support (If applicalbe)	Quantity of Items	Multi-Year Funding Request	Expense Frequency	Quantity of Expense Periods	Undiscounted Cost per Item, per Expense Period	Percentage of Expense Eligible	Percentage of Usage Eligible	Total Eligible Undiscounted Cost	Source of HCP Contribution
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