FCC Form 465

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

Approval by OMB 3060—0804

Estimated time per response: 1 hour

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

Form 465 Application Number (assigned by RHCD) 43176120

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 11902	2 Consortium Name	
3 HCP Name Central Peninsula Hospital	4 HCP FCC Registration Number (FCC RN) 0006303416	
5 Contact Name Bob Wh		
6 Address Line 1 250 Hospital Place		
7 Address Line 2	8 County Kenai Peninsula	
9 City Soldotna	10 State AK	11 ZIP Code 99669
12 Phone # (907) 714-4715	13 Fax # (907) 714-4904	14 E-mail bwattam@cpgh.org

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?
- [X] Yes, complete Block 2
- [ ] No, go to Block 3.

16 Contact Name Dan J Kettwich	17 Organization ADS Advanced Data Services, Inc.	
18 Address Line 1 Post Office Box 117		
19 Address Line 2		
20 City Saltillo	21 State TX	22 ZIP Code 75478
23 Phone # (281) 465-8888	24 Fax # (281) 465-8888	25 E-mail dkettwich@adsadsi.com

Block 3: Funding Year Information

26 Funding Year (Check only one box)
- [ ] Year 2016 (7/1/2016-6/30/2017)
- [X] Year 2017 (7/1/2017-6/30/2018)
- [ ] Year 2018 (7/1/2018-6/30/2019)

Block 4: Eligibility

27 Only the following types of HCPs are eligible. Indicate which category describes the applicant. (Check only one.)
- [ ] Post-secondary educational institution offering health care instruction, teaching hospital or medical school
- [ ] Community health center or health center providing health care to migrants
- [ ] Local health department or agency
- [ ] Community mental health center
- [X] Not-for-profit hospital
- [ ] Rural health clinic
- [ ] Skilled nursing facility
- [ ] Consortium of the above
- [ ] Dedicated ER of rural, for-profit hospital
- [ ] Part-time eligible entity

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:
- [ ] Both Telecommunications & Internet Services
- [X] Telecommunications Service ONLY
- [ ] Internet Service ONLY

Block 6: Certification

31 [X]	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 [X]	I certify that the health care provider has followed any applicable State or local procurement rules.
33 [X]	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 [X]	I certify that the health care provider is a non-profit or public entity.
35 [X]	I certify that the health care provider is located in a rural area. Visit the Eligible Rural Areas Search Tool on the Telecommunications Program web page at http://usac.org/rhc/telecommunications/tools/rural/search/search.asp or contact RHCD at (800) 453-1546 for a listing of rural areas.
36 [X]	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 Electronically signed	38 Date 18-May-2017
39 Printed name of authorized person Dan J Kettwich	40 Title or position of authorized person Consultant
41 Employer of authorized person ADS - Advanced Data Services	42 Employer's FCC RN 0015361231

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

This form should be submitted online through the RHC Program online application system, My Portal.
https://forms.universalservice.org/usaclogin/login.asp

Block 1: HCP Location Information (continued)

Legal Entity Name: Central Peninsula Hospital

Contact Employer: Central Peninsula Hospital

Title: Information Services Director

Block 4: Eligibility (continued)

Provide a brief explanation of why this site qualifies as the organization type selected.

Tribal affiliation:

- [ ] On Tribal Lands
- [ ] Operated by the Indian Health Service
- [ ] Otherwise Affiliated with a Tribe
- [X] N/A

Additional Information

Employer Identification Number (EIN): 92-0077523

National Provider Identifier (NPI): 1528062429

Explanation if no NPI:

Organization Taxonomy Code: 282NR1301X

Site Taxonomy Code: 282NR1301X

Explanation if no Site Taxonomy Code:

Block 5: Request for Services (continued)

Requested Contract Period: July 1, 2017 - June 30 , 2018 p

Number of Days USAC Should Post: 28

Posting End Date: 28 days after posting

Expected Bid Evaluation Period (Days): 9

Identify Anticipated Application(s) and Use(s) of the Supported Connection

	Capability	Usage Level	Usage Period
Category: Interactive			
X	Distance learning/training	Moderate	24/7
X	Real-time remote examination, consultation, and/or monitoring	Moderate-Heavy	24/7
X	Video conferencing	Moderate	24/7
X	Voice service	Moderate-Heavy	24/7
	Other (describe):		
Category: Transactional			
X	Distance learning/training	Light-Moderate	24/7
X	Electronic patient billing	Moderate	24/7
X	Exchange of electronic health records	Moderate	24/7
X	Transmission of large files (e.g., X-ray images, MRI, etc)	Moderate-Heavy	24/7
	Other (describe):		
Category: Bulk			
X	Electronic patient billing	Light-Moderate	24/7
X	Exchange of electronic health records	Moderate	24/7
X	Transmission of large files (e.g., X-ray images, MRI, etc)	Moderate	24/7
X	Transmission of store and forward consultations	Light-Moderate	24/7
	Other (describe):		
Category: Miscellaneous			
	Backup/redundant connectivity		
	Other (describe):		

Bid Evaluation

Select criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services.

Criteria	Description (if 'Other')	Weight (%)
Leverage Existing Resources		20%
Quality of Transmission		20%
Reliability of Service		20%
Management capability, including solicitation compliance		10%
Cost		30%

Declaration of Assistance

Contact 1

Contact Name: Daniel J Kettwich

Organization Type: Consultant

Title: RHC MAnager

Employer: ADS Advanced Data Services, Inc.

Phone #: 2814658888

Email: dkettwich@adsadsi.com

Address Line 1: POB 117

Address Line 2:

City: Saltillo

State: TX

Zip Code: 75478

Contact 2

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Declaration of Assistance (continued)

Contact 3

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Contact 4

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Contact 5

Contact Name:

Organization Type:

Title:

Employer:

Phone #:

Email:

Address Line 1:

Address Line 2:

City:

State:

Zip Code: