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) 43202421

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 14761		2 Consortium Name	
3 HCP Name Cross Road Medical Center		4 HCP FCC Registration Number (FCC RN) 0001569193	
5 Contact Name Dale Varra			
6 Address Line 1 Mile 187 Glenn Hwy Bldg B			
7 Address Line 2 PO Box 5		8 County Valdez-Cordova	
9 City Glennallen		10 State AK	11 ZIP Code 99588-0005
12 Phone # (907) 822-3203 158	13 Fax # (888) 802-6248		14 E-mail dvarra@crossroadmc.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 Daniel 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 702	24 Fax # 888-802-6428		25 E-mail dkettwich@adsadsi.com

Block 3: Funding Year Information

26 Funding Year (Check only one box)

[X] Year 2020 (07/01/2020 - 06/30/2021) [ ] Year 2021 (07/01/2021 - 06/30/2022) [ ] Year 2022 (07/01/2022 - 06/30/2023)

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
- [X] Community health center or health center providing health care to migrants
- [ ] Local health department or agency
- [ ] Community mental health center
- [ ] 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 The HCP is requesting reduced rates for:
- [X] Telecommunications Service

Block 6: Certification

31	[X] I certify under penalty of perjury that I am authorized to submit this request on behalf of the applicant or consortium.
32	[X] I certify under penalty of perjury that the applicant has complied with all applicable state, Tribal, or local procurement rules.
33	[X] I certify under penalty of perjury that all requested RHC Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the applicant is legally authorized to provide under the law of the state in which the services are provided.
34	[X] I certify under penalty of perjury that the applicant seeking supported services is a public or non-profit entity that falls within one of the seven categories set for in the definition of health care provider listed in 47 CFR § 54.600 of the Commission's rules.
35	[X] I certify under penalty of perjury that the applicant seeking support services is physically located in a rural area as defined in section 47 CFR § 54.600 of the Commission's rules.
36	[X] I certify under penalty of perjury that the applicant has reviewed and will comply with all applicable RHC Program requirements.
	[X] I certify under penalty of perjury that I have examined this request and all attachments, and to the best of my knowledge, information, and belief, all statements contained herein and in any attachments are true.
	[X] I certify under penalty of perjury that the supported services will not be sold, resold, or transferred in consideration for money or any other thing of value.
	[X] I certify under penalty of perjury that the applicant satisfies all of the requirements under section 254 of the Communications Act and applicable Commission rules.
	[X] I understand that all documentation associated with this request must be retained for a period of at least five years pursuant to 47 CFR § 54.631, or as otherwise prescribed by the Commission's rules.

37 Signature Electronically signed	38 Date 08-Mar-2020
39 Printed name of authorized person Dan J Kettwich	40 Title or position of authorized person RHC Manager
41 Employer of authorized person ADS Advanced Data Services, Inc	42 Employer's FCC RN 0001571827

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.

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 REQUIRED BY THE PAPERWORK REDUCTION ACT

Part 54 of the Federal Communications Commission's (FCC) rules authorize the FCC to collect the information requested in this form. Responses to the questions herein are required to obtain the benefits sought by this form. Failure to provide all requested information will delay processing or result in the form being returned without action. Information requested by this form will be available for public inspection. The information provided will be used to determine whether approving this request is in the public interest.

We have estimated that each response to this collection of information will take 1 hour. Our estimate includes the time to read the instructions, look through existing records, gather and maintain the required data, and actually complete and review the form or response. If you have any comments on this estimate, or on how we can improve the collection and reduce the burden it causes you, please write the Federal Communications Commission, AMD-PERM, Paperwork Reduction Project (3060-0804), Washington, DC 20554. We will also accept your comments via the Internet if you send them to pra@fcc.gov. Please DO NOT SEND COMPLETED APPICATIONS 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 PAPEWORK REDUCTION ACT OF 1995, P.L.104-13, OCTOBER 1, 1995, 44 U.S.C.§ 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: Cross Road Medical Center

Contact Employer: Cross Road Health Ministries

Title: IT Manager/CIO

Block 4: Eligibility (continued)

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

Please note: http://adsadsi.com/itb_year_23.shtml for our Invitation to Bid.

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): 92-0126047

National Provider Identifier (NPI): 1609871391

Explanation if no NPI:

Organization Taxonomy Code: 261QF0400X

Site Taxonomy Code: 261QF0400X

Explanation if no Site Taxonomy Code:

Block 5: Request for Services (continued)

Requested Contract Period: MTM or up to 5 year contract w

Number of Days USAC Should Post: 28

Posting End Date: 28 days after posting

Expected Bid Evaluation Period (Days): 1

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	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	24/7
	Other (describe):		
Category: Bulk			
X	Electronic patient billing	Light-Moderate	24/7
X	Exchange of electronic health records	Light-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	Moderate	24/7
	Other (describe):		
Category: Miscellaneous			
X	Backup/redundant connectivity	Moderate	24/7
	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 (%)
Cost		35%
Leverage Existing Resources		20%
Bandwidth		15%
Contract modification provisions		15%
Quality of Transmission		15%

Declaration of Assistance

Contact 1

Contact Name: Daniel J Kettwich

Organization Type: Consultant

Title: Mr

Employer: ADS Advanced Data Services, Inc.

Phone #: 281-465-8888

Email: dkettwich@adsadsi.com

Address Line 1: Post Office Box 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: