

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

Form 465 Application Number (assigned by RHCD) 43202807

**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 12780                        | 2 Consortium Name                                 |                              |
| 3 HCP Name Eastern Aleutian Tribes - Adak | 4 HCP FCC Registration Number (FCC RN) 0013817309 |                              |
| 5 Contact Name Paul Mueller               |   |                              |
| 6 Address Line 1 100 Mechanic Road        |   |                              |
| 7 Address Line 2                          | 8 County Aleutians East                           |                              |
| 9 City Adak                               | 10 State AK                                       | 11 ZIP Code 99546            |
| 12 Phone # (970) 277-1440                 | 13 Fax # (888) 802-6248                           | 14 E-mail paulm@EATribes.net |

**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? | <input checked="" type="checkbox"/> Yes, complete Block 2<br><input type="checkbox"/> 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)  |
| <input checked="" type="checkbox"/> Year 2020 (07/01/2020 - 06/30/2021) <input type="checkbox"/> Year 2021 (07/01/2021 - 06/30/2022) <input type="checkbox"/> 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.)                  |   |
| <input type="checkbox"/> Post-secondary educational institution offering health care instruction, teaching hospital or medical school | <input checked="" type="checkbox"/> Rural health clinic             |
| <input type="checkbox"/> Community health center or health center providing health care to migrants                                   | <input type="checkbox"/> Skilled nursing facility                   |
| <input type="checkbox"/> Local health department or agency  | <input type="checkbox"/> Consortium of the above                    |
| <input type="checkbox"/> Community mental health center   | <input type="checkbox"/> Dedicated ER of rural, for-profit hospital |
| <input type="checkbox"/> Not-for-profit hospital  | <input type="checkbox"/> 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: ☒ Telecommunications Service

**Block 6: Certification**

|  |  |
|--|--|
| 31 <input checked="" type="checkbox"/> I certify under penalty of perjury that I am authorized to submit this request on behalf of the applicant or consortium.  |  |
| 32 <input checked="" type="checkbox"/> I certify under penalty of perjury that the applicant has complied with all applicable state, Tribal, or local procurement rules.   |  |
| 33 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> 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 <input checked="" type="checkbox"/> I certify under penalty of perjury that the applicant has reviewed and will comply with all applicable RHC Program requirements.  |  |
| <input checked="" type="checkbox"/> 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.   |  |
| <input checked="" type="checkbox"/> 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.  |  |
| <input checked="" type="checkbox"/> 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.   |  |
| <input checked="" type="checkbox"/> 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 19-Mar-2020                                      |
| 39 Printed name of authorized person<br>Dan J Kettwich   | 40 Title or position of authorized person<br>RHC Manager |
| 41 Employer of authorized person<br>ADS Advanced Data Services, Inc  | 42 Employer's FCC RN<br>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-PER, 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](mailto:pra@fcc.gov). Please DO NOT SEND COMPLETED APPLICATIONS 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 PAPERWORK 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: Eastern Aleutian Tribes

Contact Employer: Eastern Aleutian Tribes

Title: CEO

**Block 4: Eligibility (continued)**

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

Please note our Invitation to Bid at [http://adsadsi.com/itb\\_year\\_23.shtml](http://adsadsi.com/itb_year_23.shtml)

Tribal affiliation:

- ☒ On Tribal Lands
- ☐ Operated by the Indian Health Service
- ☒ Otherwise Affiliated with a Tribe
- ☐ N/A

**Additional Information**

Employer Identification Number (EIN): 92-0139107

National Provider Identifier (NPI): 1285796094

Explanation if no NPI:

Organization Taxonomy Code: 261QC1500X

Site Taxonomy Code: 261QC1500X

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   |                |              |
| <input checked="" type="checkbox"/> Distance learning/training                                    | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Real-time remote examination, consultation, and/or monitoring | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Video conferencing  | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Voice service   | Moderate       | 24/7         |
| <input type="checkbox"/> Other (describe):  |                |              |
| Category: Transactional   |                |              |
| <input checked="" type="checkbox"/> Distance learning/training                                    | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Electronic patient billing                                    | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Exchange of electronic health records                         | Moderate       | 24/7         |
| <input checked="" type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc)    | Moderate       | 24/7         |
| <input type="checkbox"/> Other (describe):  |                |              |
| Category: Bulk  |                |              |
| <input checked="" type="checkbox"/> Electronic patient billing                                    | Light-Moderate | 24/7         |
| <input checked="" type="checkbox"/> Exchange of electronic health records                         | Light-Moderate | 24/7         |
| <input checked="" type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc)    | Light-Moderate | 24/7         |
| <input checked="" type="checkbox"/> Transmission of store and forward consultations               | Light-Moderate | 24/7         |
| <input type="checkbox"/> Other (describe):  |                |              |
| Category: Miscellaneous   |                |              |
| <input checked="" type="checkbox"/> Backup/redundant connectivity                                 | Moderate       | 24/7         |
| <input type="checkbox"/> 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%        |
| Reliability of Service                      |                          | 10%        |
| Contract modification provisions            |                          | 10%        |
| Bandwidth                                   |                          | 10%        |
| Prior experience including past performance |                          | 10%        |
| One vendor solution                         |                          | 5%         |

## Declaration of Assistance

### Contact 1

Contact Name: Daniel J Kettwich

Organization Type: Consultant

Title: RHC Manager

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: