



Nebraska Telehealth Pilot Program Application Form 2026

Section I: General Information

Original Revised

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| 1. Funding Year: | | 3. License Number: | |
| 2. Entity Name: | | 4. Internet Provider Name: | |

Section II: Child Care Provider Details

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|---|--|----------------------------------|--|----------|--|
| 1. Entity Address: | | | | | |
| 2. Entity Telephone Number: | | | | | |
| 3. Authorized Representative Name: | | | | | |
| 4. Authorized Representative Email Address: | | | | | |
| 4a. City: | | 4b. State | | 4c. Zip: | |
| 5. Number of Infants Authorized: | | | | | |
| 6. Description of Devices to be Used: | | 7. Number of Devices to be used: | | | |
| 8. Internet Service Provider Name: | | | | | |
| 9. Internet Service Provider Services Subscribed to (e.g. speed tier package, voice, data): | | | | | |
| 10. Monthly Cost of Internet Services: | | | | | |

Attach:

- NDHHS License
- Other supporting documentation if applicable.

APPLICANT CERTIFICATION

- I certify that I am authorized to submit this request on behalf of the childcare center.
- I certify that I have examined this request and to the best of my knowledge, all information contained on the application and in all attachments and supporting documents is true and correct.
- I certify that I have verified that the service provider has been certificated in Nebraska for purposes of receiving telehealth funding.
- I agree to perform and adhere to all requirements, and to comply with all state and federal regulations and requirements pertaining to this program.
- I understand that if any portion of the internet services subscribed to is changed or modified in whole or part, I will immediately notify the Nebraska Public Service Commission of this change. I also understand that support can only be provided to the service provider to offset the cost of service and that the support is used to provide affordable connectivity for access to health care monitoring. Support received may not be used for any other purpose other than that authorized by the Commission.

Printed Name of Authorized Person

Date

Title/Position of Authorized Person

Employer

Signature of Authorized Person