

6. Circuit end location:

8: Service end date:

date:

7. Expected service start

Nebraska Telehealth Program Application Form

Section I: General Information Original Revised 1. USAC Funding Year: 3. USAC Funding Request Number (FRN): 2. Funding Request 4. Multi-year Contract: Type: Section II: Health Care Provider (HCP) Details 1. Filing HCP name: 2. Filing HCP number: 3. Filing HCP entity type: 4. Filing HCP mailing address: 4a. Filing HCP City: 4b. Filing HCP State 4c. Filing HCP Zip: 5. Filing HCP contact name (first and last): 6. Filing HCP phone 7. Filing HCP enumber: mail: 8. Participating HCP name: 9. Participating HCP number: 10. Participating HCP street address: 10a. Participating 10b. Participating 10c. Participating HCP City: **HCP State** HCP Zip: 11. Participating HCP facility type: 12. Participating HCP contact name (first and 13. Participating HCP 14. Participating HCP e-mail: phone number: Section III: Single Eligible Expense Funding Request Details (For individual HCP, single eligible expense requests) 1: Category of expense: 9. New service or existing service? 2. Expense Type (e.g. T-1, 10. Date contract signed: Ethernet, etc): 3. Requested Download 11. Length of initial Speed: contract term: 4. Requested Upload 12. Expense frequency: Speed: 5. Circuit start location: 13. Number of expense

periods:

charge:

support:

14. Undiscounted cost per expense period:15. One-time installation

16. Percent eligible for

Section IV: Multiple Eligible Expenses and Consortium Requests for Funding

Signature of Authorized Person

(Attach the Network Cost Worksheet that was submitted with FCC-462) 1. Total undiscounted estimate for eligible recurring costs: 2. Total undiscounted estimate for eligible non-recurring costs: 3. For consortium applicants: Do you collect membership fees from participating HCPs? If so, please describe how membership fees are determined. Section V: Funding Request Summary Breakdown 1. Total Estimated Undiscounted Eligible Cost: 2. NE Telehealth Funding Requested (up to 25 percent of total eligible cost): 3. Rurality Classification*: 4. Medically Underserved Area/Population (MUA/P) See USAC Rurality Tier Search Tool: 5. Please provide the current source of funding for the 35 percent HCP contribution. **Section VI: Service Provider Details** 1. Name of Service 4. NE Code: Provider: 2. Service Provider 5. Service Provider Identification Contact Name: Number (SPIN): 3. Service Provider phone 6. Service Provider e-mail: number: Attach: ☐ FCC Form 462 ☐ Network Cost Worksheet if applying as an individual HCP with multiple eligible expenses or a Consortium. ☐ Copy of the *selected* bid response. ☐ Authorization Form(s) if applicable (i.e. Letters of Agency, Letters of Exemption, Third-Party Authorizations). ☐ Other supporting documentation if applicable. APPLICANT CERTIFICATION ☐ I certify that I am authorized to submit this request on behalf of the healthcare provider or consortium. ☐ 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 grant requirements, and to comply with all state and federal regulations and requirements pertaining to this program. ☐ I understand that if any portion of the current funding source for the 35 percent HCP contribution is from another grant, the applicant can only be approved for a total grant award through this program for any remainder of the 35 percent HCP contribution requirement that is not covered by an alternate grant source, up to the maximum 25 percent state funding match. ☐ I understand that if applying as a Consortium, if approved for support available under this program and the Consortium collects membership fees that go toward the 35 percent HCP contribution requirement by USAC, that membership fees shall be adjusted or refunded so that membership fees used toward the 35 percent HCP contribution when combined with federal and state funding sources should not exceed 100 percent of eligible costs. (For instance, if a Consortia receives 65 percent of the total network cost from USAC/federal funding and is approved for 25 percent of the total network cost in state funding, then only up to the remaining 10 percent can be collected from consortia members through membership fees.) Printed Name of Authorized Person Date Title/Position of Authorized Person **Employer**

Nebraska Telehealth Program Application Form Field Descriptions

Section General Information	Field #	Field Description
USAC Funding Years Select the funding year for which support is being requested.		
Funding Request Type: Indicates whether the funding request is for an individual health care provider (IVCP), or a consortium. Will-year Contract: Indicates whether the request is for a multi-year funding commitment.	1	
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