Nebraska Telehealth Program
Application Form

Section I: General Information   Original   Revised

1. USAC Funding Year:		3. USAC Funding Request Number (FRN):	
2. Funding Request Type:		4. Multi-year Contract:	

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 number:		7. Filing HCP e-mail:	

8. Participating HCP name:	
9. Participating HCP number:	
10. Participating HCP street address:	

10a. Participating HCP City:		10b. Participating HCP State		10c. Participating HCP Zip:	

11. Participating HCP facility type:	
12. Participating HCP contact name (first and last):	

13. Participating HCP phone number:		14. Participating HCP e-mail:	

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, Ethernet, etc):		10. Date contract signed:	
3. Requested Download Speed:		11. Length of initial contract term:	
4. Requested Upload Speed:		12. Expense frequency:	
5. Circuit start location:		13. Number of expense periods:	
6. Circuit end location:		14. Undiscounted cost per expense period:	
7. Expected service start date:		15. One-time installation charge:	
8: Service end date:		16. Percent eligible for support:	

Section IV: Multiple Eligible Expenses and Consortium Requests for Funding
(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 Provider:		4. NE Code:	
2. Service Provider Contact Name:		5. Service Provider Identification Number (SPIN):	
3. Service Provider phone number:		6. Service Provider e-mail:	

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

_____
Signature of Authorized Person

Nebraska Telehealth Program
Application Form Field Descriptions

Field #	Field Description
Section I: General Information	
1	USAC Funding Year: Select the funding year for which support is being requested.
2	Funding Request Type: Indicates whether the funding request is for an individual health care provider (HCP), or a consortium.
3	USAC Funding Request Number (FRN): This is a unique number assigned by USAC on FCC Form 462.
4	Multi-year Contract: Indicate whether the request is for a multi-year funding commitment.
Section II: Health Care Provider (HCP) Details	
1	Filing HCP name: Name of the HCP entity that filed the request.
2	Filing HCP number: The unique identifier that USAC assigns to an eligible health care provider site.
3	Filing HCP entity type: Select the appropriate entity type for the HCP entity that filed the request.
4	Filing HCP mailing address: The mailing address of the HCP entity that filed the request.
4a-c	Filing HCP city, state, zip: This field should include the city, state, zip as it pertains to the address in Section II, Field 4.
5	Filing HCP contact name (first and last): Contact person name for the HCP filing the request.
6	Filing HCP phone number: Phone number for the contact person of the HCP filing the request.
7	Filing HCP e-mail address: E-mail address for the contact person of the HCP filing the request.
8	Participating HCP name: Name of the HCP receiving services.
9	Participating HCP number: The unique identifier that USAC assigns to an eligible health care provider site.
10	Participating HCP street address: The street address where the participating HCP site is located.
10a-c	Participating HCP city, state, zip: This field should include the city, state, zip as it pertains to the address in Section II, Field 10.
11	Participating HCP facility type: Select the appropriate entity type for the participating HCP entity.
12	Participating HCP contact name (first and last): Contact person name for the participating HCP.
13	Participating HCP contact phone number: Phone number for the contact person of the participating HCP.
14	Participating HCP contact e-mail address: E-mail address for the contact person of the participating HCP.
Section III: Single Eligible Expense Funding Request Details	
1	Category of expense: The category of expense for funding request (e.g. leased/tariffed facilities or services, network equipment, etc.).
2	Expense Type (e.g. T-1, Ethernet, etc.): Enter the expense type for the funding request, such as T-1, Ethernet, etc.
3	Requested Download Speed: Enter the download speed requested, in Mbps.
4	Requested Upload Speed: Enter the upload speed requested, in Mbps.
5	Circuit start location: Enter the physical location where the circuit originates, if applicable.
6	Circuit end location: Enter the physical location where the circuit terminates, if applicable.
7	Expected service start date: Enter the date the service is expected to start.
8	Service end date: Enter the date the service is expected to end.
9	New service or existing service: Indicate whether the service is a new service or an existing service.
10	Date contract signed: The date the contract or service agreement with the vendor was signed.
11	Length of initial contract term: Enter the length of the initial contract term, prior to renewals.
12	Expense frequency: The frequency of the expense for support request (e.g. monthly, quarterly, semi-annual, annual, one-time).
13	Number of expense periods: The quantity of expense periods.
14	Undiscounted cost per expense period: Enter the undiscounted cost per expense period for the connection/service.
15	One-time installation charge: Enter any one-time installation charges being requested.
16	Percent of expense eligible for support: The percentage of expense eligible for support. This should account for usage and expense type.
Section IV: Multiple Eligible Expenses and Consortium Requests for Funding	
1	Total undiscounted estimate for eligible recurring costs: Enter the undiscounted cost for recurring costs.
2	Total undiscounted estimate for eligible non-recurring costs: Enter the undiscounted cost for non-recurring costs.
3	For consortium applicants that collect membership fees from participating HCPs, describe how membership fees are determined. If necessary, a separate sheet describing membership fees may be attached to the application.
Section V: Funding Request Summary Breakdown	
1	Total Estimated Eligible Undiscounted Cost: The total estimated eligible undiscounted cost, accounting for adjustments for ineligible expenses and ineligible usage.
2	NE Telehealth Funding Requested (up to 25 percent of total eligible cost): The amount of NE Telehealth funding requested.
3	Rurality Classification: Select the rurality classification as defined in the USAC Rurality Tool
4	Medically Underserved Area/Population (MUA/P): Select the MUA/P classification as defined in the USAC Rurality Tool.
5	Provide the current source of funding for the 35 percent HCP contribution.
Section VI: Service Provider Details	
1	Name of Service Provider: The name of the selected service provider.
2	Service Provider Contact Name: The contact person name for the selected service provider.
3	Service Provider phone number: The phone number for the service provider contact person.
4	NE Code: Enter the selected service provider's NE Code as assigned by the Nebraska Public Service Commission. The service provider must be certificated in Nebraska for purposes of receiving telehealth funding.
5	Service Provider Identification Number (SPIN): Enter the selected service provider's SPIN number.
6	Service Provider e-mail: The e-mail address for the service provider contact person.