

**Rural Health Care (RHC) Universal Service  
Request for Services Form**

USAC Internal Use Only	
FCC Form 461 Application Number: 100053527	FCC Form 460 Number: 14599-00004
Posting Start Date: 01/12/2022	Posting End Date: 02/09/2022
Allowable Contract Selection Date (ACSD): 02/10/2022	Form 461 Friendly Name: 2022 FY 461

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

Block 1: General Information		Program Type: Healthcare Connect Fund	
1 Funding Year 2022	2 HCP Number 14599		
3 Site Name/Consortium Name Ward Memorial Hospital			
4 Address Line 1 406 South Gary Avenue			
5 Address Line 2	6 County Ward		
7 City Monahans	8 State TX	9 Zip Code 79756	
Geolocation			

Block 2: Individual HCP Site Request for Services		
10 <input type="checkbox"/> Applicant has prepared and is submitting an RFP with this form. <input checked="" type="checkbox"/> Applicant has not and will not prepare an RFP.		
10a Requested contract period month to month up to 60		
10b Expected bid evaluation period 28		
11 Number of days USAC should post: 28		Posting end date: 28 days after posting
12 Category of Expense Requested (check all applicable): <input checked="" type="checkbox"/> Network Equipment <input checked="" type="checkbox"/> Leased/Tariffed Facilities or Services		
Identify Anticipated Application(s) and Use(s) of the Supported Connection (Select all that apply. Describe usage level and usage period for all selected.)		
Capability	Usage Level	Usage Period
<u>Category: Interactive</u>		
<input checked="" type="checkbox"/> Distance learning/training	Heavy	24/7
<input checked="" type="checkbox"/> Real-time remote examination, consultation, and/or monitoring	Heavy	24/7
<input checked="" type="checkbox"/> Video conferencing	Heavy	24/7
<input type="checkbox"/> Voice service		
<input type="checkbox"/> Other (describe): _____		
<u>Category: Transactional</u>		
<input checked="" type="checkbox"/> Distance learning/training	Heavy	24/7
<input checked="" type="checkbox"/> Electronic patient billing	Heavy	24/7
<input checked="" type="checkbox"/> Exchange of electronic health records	Heavy	24/7
<input checked="" type="checkbox"/> Internet access	Heavy	24/7

<input checked="" type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.)	Heavy	24/7
<input type="checkbox"/> Other (describe): _____		
<b>Category: Bulk</b>		
<input checked="" type="checkbox"/> Electronic patient billing	Heavy	24/7
<input checked="" type="checkbox"/> Exchange of electronic health records	Heavy	24/7
<input checked="" type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.)	Heavy	24/7
<input checked="" type="checkbox"/> Transmission of store and forward consultations	Heavy	24/7
<input type="checkbox"/> Other (describe): _____		
<b>Category: Miscellaneous</b>		
<input checked="" type="checkbox"/> Backup/redundant connectivity	Heavy	24/7
<input type="checkbox"/> Other (describe): _____		
12b Applicant requesting services for an off-site data center: <input type="radio"/> Yes <input checked="" type="radio"/> No		
If yes, provide HCP Number(s): _____		
12c Applicant requesting services for an off-site administrative office <input type="radio"/> Yes <input checked="" type="radio"/> No		
If yes, provide HCP Number(s): _____		
13 Contact for Request for Services:		
<input type="radio"/> Same as HCP Physical Location Contact <input type="radio"/> Same as HCP Primary Account Holder <input checked="" type="radio"/> Other		
13a If other, provide full contact information:		
Contact Name <b>Geoff Boggs</b>	Organization Name <b>USF Healthcare Consulting, Inc.</b>	
Contact Name Title <b>CEO</b>	Email <b>gboggs@uasave.com</b>	
Phone <b>(502) 228-1907</b> Ext. _____	Fax _____	
Address Line 1 <b>PO Box 326</b>		
Address Line 2 _____		
City <b>Prospect</b>	State <b>KY</b>	Zip Code <b>40059</b>
<b>Block 3: Consortium Request for Services</b>		
14 Participating Entities (list all sites, eligible and ineligible, participating in this request for services):		
15 Indicate whether the Consortium plans to utilize an RFP:		
<input type="checkbox"/> Applicant has prepared and is submitting an RFP with this form. If selected, complete 15a.		
<input type="checkbox"/> Applicant has not and will not prepare an RFP.		
15a Applicant is submitting an RFP because:		
<input type="checkbox"/> It is seeking more than \$100,000 in program support	<input type="checkbox"/> Of state, Tribal, or local procurement rules	
<input type="checkbox"/> It is seeking support for infrastructure	<input type="checkbox"/> The applicant has elected to use an RFP	
15b Requested contract period		
15c Expected bid evaluation period		
16 Number of Days Posted:		
Number of days USAC should post: _____ Posting end date: _____		
17 Category of Expense Requested:		
<input type="checkbox"/> Network Design	<input type="checkbox"/> Leased/Tariffed Facilities or Services	
<input type="checkbox"/> Network Equipment	<input type="checkbox"/> Network Management/Maintenance/Operations Cost (not captured elsewhere)	
<input type="checkbox"/> Infrastructure/Outside Plant		
17a If requesting only Infrastructure/Outside Plant, enter FCC Form 461 Application Number in which the Consortium previously requested Leased/Tariffed Facilities or Services.		
FCC Form 461 Application Number: _____		
<input type="checkbox"/> I certify that the prior FCC Form 461 resulted in no responsive bids.		

18 Description of Services Requested (Required to provide a summary of RFP if submitting one):

19 Contact for Request for Services:  
 Same as Project Coordinator       Same as Assistant Project Coordinator       Other

If other, provide full contact information:

Contact Name	Organization Name	
Contact Name Title	Email	
Phone	Ext.	Fax
Address Line 1		
Address Line 2		
City	State	Zip Code

**Block 4: Declaration of Assistance**

20 Have any consultants, service providers, or any other outside experts, whether paid or unpaid, aided in the preparation of the FCC Forms 460 or 461, RFP, bid evaluation, or network plan?  
 Yes       No

21 List the contact information for all consultants, service providers, and outside experts that assisted in preparing any part of the FCC Forms 460, 461, RFP, bid evaluation, or network plan. [See attached](#)

a. Name	b. Organization Type	
c. Title/Role	d. Employer	
e. Address Line 1		
f. Address Line 2		
g. City	h. State	i. Zip Code
Phone	Ext.	Email
Nature of Relationship		

**Block 5: Bid Evaluation**

22 Select selection criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services. Attach supplemental information (if necessary).

Criteria	Weight	Minimum Requirement
a. <b>Cost</b>	60	See attached for more information
b. <b>Prior experience, including past performance</b>	40	
c.		
d.		
e.		
f.		
g.		
h.		

- Applicant has no disqualification factors that will be used to remove bids or bidders from further consideration.

Disqualification Factors

HCP will not accept bids from agents or wholesalers.

### Block 6: Additional Documentation

23 List all supporting documentation (RFP, Network Plan, etc) that is required to be submitted with this form.

Type of Documentation

a.

b.

c.

d.

e.

### Block 7: Certifications

- 24  I certify under penalty of perjury that I am authorized to submit this request on behalf of the healthcare provider or consortium.
- 25  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.
- 26  I certify under penalty of perjury that the applicant seeking supported services has complied with any applicable state, Tribal, or local procurement rules.
- 27  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 health care provider is legally authorized to provide under the law of the state in which the services are provided.
- 28  I certify under penalty of perjury that the applicant seeking supported services satisfies all of the requirements under section 254 of the Communications Act, 47 U.S.C. § 254, and applicable Commission rules.
- 29  I certify under penalty of perjury that the applicant seeking support has reviewed and is compliant with all applicable RHC Program requirements.
- 30  I understand that all documentation associated with this request, including a copy of the signed Request for Services (FCC Form 461), any bids/contracts resulting from the FCC Form 461 posting, scoring sheet, and other information that was used in the decision making process, 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.
- I certify under penalty of perjury that the applicant seeking supported services is a nonprofit or public entity that falls within one of the seven categories set forth in the definition of health care provider listed in 47 CFR §54.600 of the Commission's rules.
- I certify under penalty of perjury that the applicant seeking supported services is physically located in a rural area as defined in section 47 CFR § 54.600 of the Commission's rules, or is a member of a consortium which satisfies the majority-rural composition requirements set forth in 47 CFR § 54.607 of the Commission's rules.
- I certify under penalty of perjury that the services will not be sold, resold, or transferred in consideration for money or any other thing of value.

<input type="checkbox"/>	I certify and acknowledge, under penalty of perjury, that the applicant or consortium will comply with all applicable Connected Care Pilot Program rules, requirements and procedures, including the requirement to pay 15% of the costs for supported items from eligible sources, and all applicable federal and state laws, including the Americans with Disabilities Act, the Rehabilitation Act, the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law.
<input type="checkbox"/>	I certify and acknowledge, under penalty of perjury, that the applicant or consortium will comply with the applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws.
<input type="checkbox"/>	I certify, under penalty of perjury, to the best of my knowledge, that the applicant or consortium is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services and/or equipment eligible for support under the Connected Care Pilot Program.
<input type="checkbox"/>	I certify and acknowledge, under penalty of perjury, that all requested equipment and services funded under the Connected Care Pilot Program will be used for their intended purposes.
31 Signature	32 Date <b>Mon Jan 10 08:39:45 EST 2022</b>
33 Printed Name of Authorized Person <b>Elizabeth W. Boggs-Goodknight</b>	
34 Title/Position of Authorized Person <b>COO</b>	
35 Phone <b>(502) 228-1907</b> Ext. <b>100</b>	36 Email <b>egoodknight@uasave.com</b>
37 Employer <b>USF Healthcare Consulting, Inc</b>	38 Employer's FCC RN <b>0018694075</b>

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](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**

## Request For Services (cont.)

Identify services for which the applicant is requesting bids. Select all that apply. If appropriate, enter a bandwidth range for each service the applicant is requesting.

Services	Minimum Download Bandwidth (Mbps)	Maximum Download Bandwidth (Mbps)	Minimum Upload Bandwidth (Mbps)	Maximum Upload Bandwidth (Mbps)	The applicant is seeking bids for similar services if appropriate.
Data	500.0	1000.0	500.0	1000.0	X
Equipment					X
Installation					X
PTP	50.0	100.0	50.0	100.0	X
Equipment					X
Installation					X
PTP to HCP 43673	50.0	100.0	50.0	100.0	X
Equipment					X
Installation					X
PTP to HCP 94946	50.0	100.0	50.0	100.0	X
Equipment					X
Installation					X

**Block 4: Declaration of Assistance (cont.)**

21 List the contact information for all consultants, service providers, and outside experts that assisted in preparing any part of the FCC Forms 460, 461, RFP, bid evaluation, or network plan.

a. Name <b>Geoff Boggs</b>	b. Organization Type <b>CONSULTANT</b>
c. Title/Role <b>CEO</b>	d. Employer <b>USF Healthcare Consulting, Inc.</b>
e. Address Line 1 <b>PO Box 326</b>	
f. Address Line 2	
g. City <b>Prospect</b>	h. State <b>KY</b>   i. Zip Code <b>40059</b>
Phone <b>(502) 228-1907</b> Ext.	Email <b>gboggs@uasave.com</b>

Nature of Relationship  
**consultant**

a. Name <b>Elizabeth Boggs-Goodknight</b>	b. Organization Type <b>CONSULTANT</b>
c. Title/Role <b>COO</b>	d. Employer <b>USF Healthcare Consulting, Inc.</b>
e. Address Line 1 <b>PO Box 326</b>	
f. Address Line 2	
g. City <b>Prospect</b>	h. State <b>KY</b>   i. Zip Code <b>40059</b>
Phone <b>(502) 228-1907</b> Ext.	Email <b>egoodknight@uasave.com</b>

Nature of Relationship  
**consultant**

a. Name	b. Organization Type
c. Title/Role	d. Employer
e. Address Line 1	
f. Address Line 2	
g. City	h. State   i. Zip Code
Phone Ext.	Email

Nature of Relationship

a. Name	b. Organization Type
c. Title/Role	d. Employer
e. Address Line 1	
f. Address Line 2	
g. City	h. State   i. Zip Code
Phone Ext.	Email

Nature of Relationship

**Block 5: Bid Evaluation (cont.)**

Criteria: **Cost**

Minimum Requirement:

Criteria: **Prior experience, including past performance**

Minimum Requirement:

**3 references from same city for like services**

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement: