

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

| USAC Internal Use Only | |
|--|----------------------------------|
| FCC Form 461 Application Number: 100055300 | FCC Form 460 Number: 94814-00001 |
| Posting Start Date: 08/18/2022 | Posting End Date: 09/15/2022 |
| Allowable Contract Selection Date (ACSD): 09/16/2022 | Form 461 Friendly Name: |

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

| Block 1: General Information | | Program Type: Connected Care Pilot Program | |
|--|-------------------------------|--|--|
| 1 Funding Year 2022 | 2 HCP Number 94814 | | |
| 3 Site Name/Consortium Name Metro Health | | | |
| 4 Address Line 1 1012 14TH ST NW STE 700 | | | |
| 5 Address Line 2 | 6 County District of Columbia | | |
| 7 City WASHINGTON | 8 State DC | 9 Zip Code 20005 | |
| Geolocation | | | |
| Block 2: Individual HCP Site Request for Services | | | |
| 10 <input checked="" type="checkbox"/> Applicant has prepared and is submitting an RFP with this form. <small>Uploaded document: Request-for-Proposal FCC-Metro Health-updated-8-16-22.docx</small> <input type="checkbox"/> Applicant has not and will not prepare an RFP. | | | |
| 10a Requested contract period up to 36 months | | | |
| 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 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 type="checkbox"/> Distance learning/training | | | |
| <input type="checkbox"/> Real-time remote examination, consultation, and/or monitoring | | | |
| <input type="checkbox"/> Video conferencing | | | |
| <input type="checkbox"/> Voice service | | | |
| <input type="checkbox"/> Other (describe): | | | |
| <u>Category: Transactional</u> | | | |
| <input type="checkbox"/> Distance learning/training | | | |
| <input type="checkbox"/> Electronic patient billing | | | |
| <input type="checkbox"/> Exchange of electronic health records | | | |
| <input type="checkbox"/> Internet access | | | |

| | | |
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| <input type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.) | | |
| <input type="checkbox"/> Other (describe): _____ | | |
| Category: Bulk | | |
| <input type="checkbox"/> Electronic patient billing | | |
| <input type="checkbox"/> Exchange of electronic health records | | |
| <input type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.) | | |
| <input type="checkbox"/> Transmission of store and forward consultations | | |
| <input type="checkbox"/> Other (describe): _____ | | |
| Category: Miscellaneous | | |
| <input type="checkbox"/> Backup/redundant connectivity | | |
| <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 Miguel McInnis | Organization Name Metro Health | |
| Contact Name Title Chief Executive Officer | Email mmcinnis@metrohealthdc.org | |
| Phone (202) 838-9271 Ext. _____ | Fax (202) 638-0749 | |
| Address Line 1 1012 14th Street, NW | | |
| Address Line 2 Suite 700 | | |
| City WASHINGTON | State DC | Zip Code 20005-3477 |
| Block 3: Consortium Request for Services | | |
| 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: <input type="radio"/> Same as Project Coordinator <input type="radio"/> Same as Assistant Project Coordinator <input type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> 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. | | |
| | 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. Cost | 40 | See attached for more information |
| | b. Management capability, including solicitation compliance | 30 | |
| | c. Personnel qualifications, including technical excellence | 10 | |
| | d. Prior experience, including past performance | 10 | |
| | e. Project Management Plan | 10 | |
| | f. | | |
| | g. | | |
| | h. | | |

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

Disqualification Factors

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. OTHER (RFP)

Document: Request-for-Proposal FCC-Metro Health-update

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 checked="checked" 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 checked="checked" 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 checked="checked" 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 checked="checked" 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 Tue Aug 16 15:36:46 EDT 2022 |
| 33 Printed Name of Authorized Person Duane Taylor | |
| 34 Title/Position of Authorized Person Chief Operating Officer | |
| 35 Phone (202) 638-0750 Ext. 9268 | 36 Email dtaylor@metrohealthdc.org |
| 37 Employer Metro Health | 38 Employer's FCC RN 0029573912 |

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. Please DO NOT SEND COMPLETED APPLICATIONS TO THIS ADDRESS.

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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.

[illegible]

Block 5: Bid Evaluation (cont.)

Criteria: **Cost**

Minimum Requirement:

Criteria: **Management capability, including solicitation compliance**

Minimum Requirement:

30

Criteria: **Personnel qualifications, including technical excellence**

Minimum Requirement:

10

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

Minimum Requirement:

10

Criteria: **Project Management Plan**

Minimum Requirement:

10

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement: