FCC Form **460**

OMB Approved 3060-0804
Estimated Time Per Response: 1 hour

Rural Health Care (RHC) Universal Service
Eligibility and Registration Form

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

Block 1: General Information

1 Date Submitted: | Form Nickname

2 Applying to:
- ◉ Determine eligibility of an HCP site
- ○ Determine eligibility of Consortium
- ○ Register an off-site data center
- ○ Register an ineligible site
- ○ Register an off-site administrative office

2a If applying as an off-site data center, list all sites (eligible and ineligible) that will use the services of this data center.

2b If applying as an off-site administrative office, list all sites (eligible and ineligible) that will use the services of this administrative office.

Block 2: Site Information – Physical Site

3 HCP Number | HCP Website

4 Site Name

5 Name of Legal Entity

6 Legal Entity FCCRN | Website

6a If the Line 5 legal entity does not have an FCC RN and only plans to participate as a consortium member, applicant may enter FCC RN for the Consortium (see instructions for more detail):

Site Contact Name

Phone | Ext. | 16 Email

Site Physical Location

Address Line 1 | Address Line 2

City | State | Zip Code

Geo Location (if no street address) | County

Block 3: Consortium Information

17 HCP Number | Consortium Website

18 Name of Consortium

19 Is the Consortium a legal entity? ○ Yes ○ No If yes, Consortium FCC RN:

20 Consortium has a written agreement allocating legal and financial responsibility. ○ Yes ○ No

If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.

21 Consortium Leader Type:
- ○ The Consortium
- ○ An eligible HCP participating in the Consortium
  HCP Number: _____
- ○ Ineligible State organization
- ○ Ineligible public sector (government) entity
- ○ Ineligible non-profit entity

A state organization, public sector entity, or non-profit entity may obtain an exemption to allow the organization to perform vendor functions and provide application assistance. Submit any such request for exemption.

22 Consortium Leader Contact Information | 23 Name of Consortium Leader

Consortium applicants are required to have a Letter of Agency from each eligible HCP that authorizes the Consortium to file forms on the HCP's behalf. Submit a Letter of Agency for each eligible HCP.

24 List participating sites by HCP Number (eligible/ineligible)

Block 4: Contact Information

25 Primary Account Holder/Project Coordinator Name

26 Employer | Employer's FCC RN

Title/Position | Employer's Website

27 Address Line 1 ○ Same as Physical Location

28 Address Line 2

29 City | 30 State | 31 Zip Code

32 Phone # | Ext. | 33 Email

Block 5: Eligibility Category

43 Select the category that describes the HCP site
(If seeking an eligibility determination for a Consortium, "Consortium of the above" will be automatically selected)

- ○ **A.** Community health center or health center providing health care to migrants
- ○ **B.** Community mental health center
- ○ **C.** Local health department/agency
- ○ **D.** Non-profit hospital
- ○ **E.** Part-time eligible entity located in an ineligible facility
- ○ **F.** Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school
- ○ **G1.** Rural health clinic
  G2. Is this a mobile rural health care provider? ☐ Yes ☐ No
- ○ **H.** Dedicated ER of rural, for-profit hospital
- ○ **I.** Skilled nursing facility
- ○ **J.** Consortium of the above

44 Provide a brief explanation of why this site qualifies as the organization type selected above:

Block 6: Additional Information

45 Non-Profit Tax ID (EIN):	47a Organization Taxonomy Code:
46 National Provider Identifier:	47b Site Taxonomy Code:
Explanation if necessary (see instructions)	Explanation if necessary (see instructions)

48 If a Non-Profit Hospital, is this a Critical Access Hospital? ☐ Yes ☐ No

49 If a Non-Profit Hospital, how many licensed patient beds are at the site? _____

50 Is the site location: ☐ On Tribal lands ☐ Otherwise affiliated with a Tribe
☐ Operated by the Indian Health Service ☐ N/A

Block 7: Certifications and Signatures

53 ☐ I certify that I am authorized to submit this request on behalf of the site or consortium.

54 ☐ I declare under penalty of perjury that I have examined this request and attachments and to the best of my knowledge, information, and belief, all information contained in this request, and in any attachments, is true and correct.

55a ☐ If applying as an individual healthcare provider site, I certify that the healthcare provider is either a non-profit, public entity or a dedicated ER of a rural for-profit hospital.

55b ☐ If applying as an individual healthcare provider site, I certify that the site is located in a FCC designated rural area, or is a grandfathered rural pursuant to 47 C.F.R. § 54.600(b)(2).

56 ☐ If applying as a consortium, I certify that the eligible healthcare providers participating in the consortium are either non-profit or public entities or dedicated ER(s) of a rural for-profit hospital.

57 ☐ I understand that all documentation associated with this request must be retained for a period of at least five years pursuant to 47. C.F.R. § 54.648, or as otherwise prescribed by the Commission's rules.

58 ☐ If applying as a consortium, I understand I must obtain letters of agency from each consortium member that grants me the authority to complete, sign, and submit all requests for the funding year(s) for which support is sought.

59 Signature	60 Date	
61 Printed Name of Authorized Person		
62 Title/Position of Authorized Person		
63 Phone Ext.	64 Email	
65 Employer	66 Employer's FCC RN	
Address Line 1		
Address Line 2		
City	State	Zip Code
Third Party Authorization Start Date	Third Party Authorization End Date	

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 your send them to 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