

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

USAC Internal Use Only	
FCC Form 461 Application Number: 100054419	FCC Form 460 Number: 35645-00005
Posting Start Date:	Posting End Date:
Allowable Contract Selection Date (ACSD):	Form 461 Friendly Name: RFP 5 - FLCH, FLACRA, UPC

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 35645		
3 Site Name/Consortium Name NY Community Broadband Partnership			
4 Address Line 1 14 Maiden Lane			
5 Address Line 2 PO Box 423	6 County		
7 City Penn Yan	8 State NY	9 Zip Code 14527	
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 type="checkbox"/> Applicant has not and will not prepare an RFP.			
10a Requested contract period			
10b Expected bid evaluation period			
11 Number of days USAC should post: _____ Posting end date: _____			
12 Category of Expense Requested (check all applicable): <input 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			

<input type="checkbox"/> Transmission of large files (e.g., X-ray images, MRI, etc.)		
<input type="checkbox"/> Other (describe): _____		
<b>Category: Bulk</b>		
<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): _____		
<b>Category: Miscellaneous</b>		
<input type="checkbox"/> Backup/redundant connectivity		
<input type="checkbox"/> Other (describe): _____		
12b Applicant requesting services for an off-site data center: <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No</span>		
If yes, provide HCP Number(s): _____		
12c Applicant requesting services for an off-site administrative office <span style="float: right;"><input type="radio"/> Yes <input type="radio"/> No</span>		
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 type="radio"/> Other		
13a 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
<b>Block 3: Consortium Request for Services</b>		
14 Participating Entities (list all sites, eligible and ineligible, participating in this request for services):		
<a href="#">(10) HCPs attached</a>		
15 Indicate whether the Consortium plans to utilize an RFP:		
<input checked="" 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. <span style="float: right; font-size: small;">Uploaded document: NY CBP Draft RFP_January 2022_FLMHCP_FLACRA_UPC.docx</span>		
15a Applicant is submitting an RFP because:		
<input type="checkbox"/> It is seeking more than \$100,000 in program support <input checked="" 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 <b>3 years</b>		
15c Expected bid evaluation period <b>7</b>		
16 Number of Days Posted:		
Number of days USAC should post: <b>28</b> Posting end date: <b>28 days after posting</b>		
17 Category of Expense Requested:		
<input type="checkbox"/> Network Design <input checked="" 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):  
 This RFP for NYCBP seeks increased Internet connections 1 site of FLMHCP, 4 sites of FLACRA, and 5 sites of UPC, which currently have inadequate broadband connectivity for their needs.

19 Contact for Request for Services:

☐ Same as Project Coordinator ☒ Same as Assistant Project Coordinator ☐ Other

If other, provide full contact information:

Contact Name Rachel L. Mehlenbacher	Organization Name Finger Lakes Migrant Health Care Project, Inc.
Contact Name Title Executive Assistant	Email rachelm@flchealth.org
Phone (315) 531-9102 Ext. 2112	Fax
Address Line 1 14 Maiden Lane	
Address Line 2 PO Box 423	
City Penn Yan	State NY Zip Code 14527

#### 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.

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). Uploaded document: NYCBP\_Network Plan

Criteria	Weight	Minimum Requirement
a. Cost	30	See attached for more information
b. Prior experience, including past performance	20	
c. Other (Proposed Implementation Timeframe)	10	
d. Other (Network IP Services such as QoS, DSCP and H.323)	20	
e. Other (Solution functions and features and suitability of vendor(s) solution)	20	
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. NETWORKPLAN

Document: NYCBP\_Network Plan - RFP 5.docx

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 <a href="#">Thu Feb 10 22:32:55 EST 2022</a>
33 Printed Name of Authorized Person <a href="#">Rachel L. Mehlenbacher</a>	
34 Title/Position of Authorized Person <a href="#">Executive Assistant</a>	
35 Phone <a href="#">(315) 531-9102</a> Ext. <a href="#">2112</a>	36 Email <a href="mailto:rachelm@flchealth.org">rachelm@flchealth.org</a>
37 Employer <a href="#">Finger Lakes Migrant Health Care Proj</a>	38 Employer's FCC RN <a href="#">0014849566</a>

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**

### Block 3: Consortium Request For Services (cont.)

14 Participating Entities (list all sites, eligible and ineligible, participating in this request for services):

[illegible]

## 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: [Prior experience, including past performance](#)

Minimum Requirement:

[See attached RFP for more information](#)

Criteria: [Other \(Proposed Implementation Timeframe\)](#)

Minimum Requirement:

[See attached RFP for more information](#)

Criteria: [Other \(Network IP Services such as QoS, DSCP and H.323\)](#)

Minimum Requirement:

[See attached RFP for more information](#)

Criteria: [Other \(Solution functions and features and suitability of vendor\(s\) solution\(s\)\)](#)

Minimum Requirement:

[See attached RFP for more information](#)

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement:

Criteria:

Minimum Requirement: