COVID-19 Telehealth Application

Federal Communications Commission

Applicants should submit their completed application form and all supporting documentation to TelehealthApplicationSupport@fcc.gov

Applicant Information [all fields mandatory unless otherwise marked]

Applicant Name

Applicant FCC Registration Number (FRN)

Applicant National Provider Identifier (Optional)

Federal Employer Identification Number (EIN or Tax ID Number)

Data Universal Numbering System (DUNS) Number

DATA Act Business Types (choose Three)

A - State Government

B - County Government

C - City or Township Government

D - Special District Government

E - Regional Organization

F - U.S. Territory or Possession

G - Independent School District

H - Public/State Controlled Institution of Higher Education

I - Indian/Native American Tribal Government (Federally-Recognized)

J - Indian/Native American Tribal Government (Other than Federally-Recognized)

K - Indian/Native American Tribal Designated Organization

L - Public/Indian Housing Authority

M - Nonprofit with 501C3 IRS Status (Other than an Institution of Higher Education)

N - Nonprofit without 501C3 IRS Status (Other than an Institution of Higher Education)

O - Private Institution of Higher Education

P - Individual

Q - For-Profit Organization (Other than Small Business)

R - Small Business

S - Hispanic-serving Institution

T - Historically Black College or University (HBCU)

U - Tribally Controlled College or University (TCCU)

V - Alaska Native and Native Hawaiian Serving Institutions

W - Non-domestic (non-U.S.) Entity

X - Other

Service Area

Contact Information [all fields mandatory]

First Name Last Name

Position Title, Company Name

Mailing Address

Street

City State Zip

Phone Number E-mail Address

Health Care Provider(s) (HCP) Information [lead fields mandatory unless otherwise noted]

Lead HCP

Facility Name

Is the Facility a Hospital?

Yes

No

Street

City State Zip

County in which address is located

FCC Registration Number (FRN)

HCP Number (Optional)

Eligibility Type

NPI (Optional)

Total Patient Population

Estimated Number of Patients to be Served by Funding Request

Additional Information on Patient Estimate (Optional)

Health Care Provider(s) (HCP) Information [HCP Two- Optional fields]

Secondary HCP

Facility Name

Is the Facility a Hospital?

Yes

No

Street

City

State

Zip

County in which address is located

FCC Registration Number (FRN)

HCP Number (Optional)

Eligibility Type

NPI (Optional)

Total Patient Population

Estimated Number of Patients to be Served by Funding Request

Additional Information on Patient Estimate (Optional)

Medical Services To Be Provided with COVID-19 Telehealth Funding (check all that apply)

- Patient-Based Internet-Connected Remote Monitoring
- Other Monitoring
- Video Consults
- Voice Consults
- Imaging Diagnostics
- Other Diagnostics
- Remote Treatment
- Other services

Additional Information on Medical Services to be Provided:

Conditions To Be Treated with COVID-19 Telehealth Funding (answer all that apply)

Would you treat COVID-19 patients directly?

- Yes
- No

Would you treat patients without COVID-19 symptoms or conditions?

- Yes
- No

If you answered "Yes" to the above question, please check at least one box below

- Other infectious diseases
- Emergency / Urgent Care
- Routine, Non-Urgent Care
- Mental Health Services (non-emergency)
- Other conditions

Additional Information on Specific Conditions to be Treated:[Required if other conditions is selected]

If yes, please explain how using COVID-19 Telehealth Program funding to treat patients without COVID-19 symptoms or conditions would free up resources that will be used to treat COVID-19. (Required if yes)

Additional Information Concerning Requested Services and Devices

What are your goals and objectives for use of the COVID-19 Telehealth Program Funding?

What is your timeline for deployment of the proposed service(s) or devices funded by the COVID-19 Telehealth Program?

What factors/metrics will you use to help measure the impact of the services and devices funded by the COVID-19 Telehealth Program?

How has COVID-19 affected health care in your geographic area (e.g, county)?

Please provide additional information about the geographic area and population you serve. Does it have large underserved or low-income patient population? Have there been recent health care provider closures or other health care deficiencies? If so, please describe such factors (Optional)

Do you plan to target the funding to high-risk and vulnerable patients?

Yes

No

If so, please describe how.

Please provide any additional information to support your application and request for funding (Optional)

Requested Funding Items

Total Amount of Funding Requested

Are you requesting funding for devices?

Yes

No

How are the devices integral to patient care?

Are the devices for patient use?

Yes

No

Are the devices for the health care provider’s use?

Yes

No

Category (Optional)

Description of Service(s) and/or Device(s)(Optional)

Quantity (for Devices)(Optional)

Total One-Time Expense(Optional)

Date [Purchased or] To Be Purchased(Optional)

Total Monthly Expense(Optional)

Number of Months for Recurring Monthly Expenses(Optional)

Supporting Cost and Estimated Patient Documentation

An applicant should provide supporting documentation for the costs indicated in its application. Such supporting documentation should summarize the expected costs of the eligible services and devices requested and may include documentation such as an invoice or quote from a vendor or service provider (or similar information). Such information should be specific enough to identify line-items to facilitate swift review of the application, and we encourage applicants to include information such as a description of the service or device, its eligibility category, the quantity ordered, the upfront and monthly expenses, and the service dates for recurring services. Additionally, applicants may provide supporting document for the estimated number of patients to be served by the funding request.

Request for confidential treatment of supporting documentation?

Yes No

Applicant requests Confidential treatment for supporting documents and information. By designating supporting documents and information as "Confidential," the applicant is deemed to have submitted a request that the material be withheld from public inspection pursuant to 47 CFR § 0.459. Applicants designating supporting documents as "Confidential" should not submit those documents in the Commission's Electronic Comment Filing System (ECFS). Email Confidential materials to TelehealthApplicationSupport@fcc.gov

Certifications

[Applicant must check all boxes and sign]

I certify under penalty of perjury that I am authorized to submit this application on behalf of the health care provider(s) listed in the application.

I certify under penalty of perjury that to the best of my knowledge, information, and belief, all information contained in this application, and in any attachments, is true and correct.

I understand that, if selected, the health care provider(s) in the application must comply with all applicable program requirements and procedures, and all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law, as waived or modified in connection with the COVID-19 pandemic, and the Coronavirus Aid, Relief, and Economic Security (CARES) Act.

I understand that, if selected, the health care providers in the application must comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws, as waived or modified in connection with the COVID-19 pandemic.

I understand that all documentation associated with this application must be retained for a period of at least three years after the last date of delivery of the supported-services provided through the COVID-19 Telehealth Program to demonstrate compliance with COVID-19 Telehealth Program rules and requirements, subject to audit.

I certify under penalty of perjury that the health care provider(s) listed in the application, to the best of my knowledge, is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services or devices eligible for support under the COVID-19 Telehealth Program.

I understand that all requested goods and services funded under the COVID-19 Telehealth Program must be used for their intended purposes.

Contact Name **Date**

If you have an issue with this form and/or need assistance please contact: TelehealthApplicationSupport@fcc.gov.