

September 1, 2014

To: Marlene H. Dortch, Secretary  
Federal Communications Commission  
Office of the Secretary  
445 12th Street, SW  
Washington, DC 20554

From: Jacob Steiner  
Prime Security & Communication, Inc.  
46 Main Street  
Suite 231  
Monsey, NY 10952

**Subject: Appeal of USAC Funding Decision - Docket 02-6**

**Request for Reconsideration**

**Request For A Waiver**

Re: 471 Application # 685013, 756208, 805150  
FRNs: 1873679, 1873604, 1873584, 1873629, 1873658 and 1873700 of funding year 2009  
FRNs: 2055678 and 2055689 of funding year 2010  
FRNs: 2182805 and 2182782 of funding year 2011

**We had previously requested a waiver for the above references FRNs. We were recently notified by Naomi Riley of the FCC that our original request was denied on the basis that we failed to demonstrate that special circumstances exist to justify a waiver of the deadline. We are asking for the FCC to reconsider the FCC decision to deny that request as we believe that special circumstances do exist that justify a waiver of the deadline.**

Our original appeal to USAC was post marked on September 27, 2013. Our the Administrator's Decision on Appeal Letter dated October 7, 2013 our appeal was denied by USAC because our Letter of Appeal had been received later that 60 days from the date of the Commitment Adjustments Letter and therefore they were not permitted to consider our Appeal and we ask the Commission waive the 60 day Appeal deadline because of special circumstances.

**There were extenuating circumstances that caused a delay in our being able to respond to the COMAD notifications. Shortly after receiving the COMAD notifications the person within our company that is in charge of our E-Rate work and who is the only one in the company that would be qualified to respond was injured and was hospitalized. After hospitalization he was bedridden at home for an extended period of time. As soon as he was able to do so, even though he was not fully back at work yet, he put together our Letter of Appeal but by that time it was later than 60 days for some of the responses. Also attached is a copy of the paperwork showing the "Notice and Proof of Claim for Disability Benefits".**

USAC gave the following explanation for originally denying the above mentioned FRNs: That funds were committed for an ineligible redundant item and that it was the Service Providers responsibility to determine that the items billed for were eligible and therefore it is the Service Provider who must make restitution.

We had previously appealed this decision based on the following:

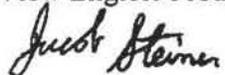
1- The Item in question is eligible

2- Based on the definition of redundancy given in the Eligible Items List the item in question was not being used in a redundant fashion based on the following: The applicant determined that the best design for their school was to use two PBX systems that are integrated to function as one system. The reason for this decision was that there are different types of telephones needed in different areas. Some areas need digital or IP based telephones and some areas need standard analog telephones. In order to have the best system for each type of phone they would use two PBXs, each one being the best choice for that type of phone. Two systems, integrated to function (together) as one, where each is serving a specific independent function from other, where both functions are needed, are not redundant.

3- Redundancy is not an integrally ineligible feature of an item. If it is the program's prerogative to make a "judgment call" and determine that even though there was no clear indication in the Eligible Items List that the way in which item was used in the FRN in question was redundant, yet they may deem it so, this should have been done in advance by the Program Integrity Assurance (PIA) group (at which time the School or Service Provider could have sent in a Letter of Appeal). If PIA did not determine that the item was used in a redundant fashion, the Service Provider certainly should not be held responsible retroactively.

4- In addition to item 3, the extended history of this item being used in the same way as it was used in the FRN for which the COMAD was issued and repeatedly being approved for funding, further demonstrates that there was no reason for the Service Provider to consider that the item was ineligible or the way in which it was being used should be considered redundant and therefore the Service Provider certainly should not be held responsible retroactively. In the case of an item that is not integrally ineligible (i.e. a telephone or a computer work station), once the item has been approved for funding, installed and funding disbursed, particularly in the case of internal connections where the Service Provider has direct cost of goods sold expenditures (which are not a shared cost like a telecommunication carrier's central office equipment) in light of the great financial loss it is an unfair burden to ask the Service Provider to take a greater responsibility for the determination of eligibility than Program Administrator (PIA) and the Service Provider should not be responsible for reimbursement of the distributed funding. As a participant in the program we take this opportunity to implore the Commission to consider the untenable position in which USAC is placing the service provider. In our opinion this particular case shows clearly how flawed the situation is. As indicated below in our original appeal, we have a situation where based on the descriptions given in the Eligible Items List the item in question is eligible, and is being used in an eligible fashion. The item being used and the way in which it is being used in the FRN for which the COMAD was issued has been through PIA review for over twelve years and has been repeatedly considered eligible and approved for funding, the program website included the item on a list of items that had been reviewed by the

program and listed a eligible items (screen shots attached) and with all this USAC expects the Service Provider to decide on their own the item or its use really isn't eligible. NOTE: The Bogen Multicom equipment is again listed on the SLD website as Eligible. Go to "Search Tools" then "View Eligible Products" and search for Bogen.

A handwritten signature in black ink that reads "Jacob Steiner". The signature is written in a cursive style with a large initial "J".

Jacob Steiner  
President

200

NOTICE AND PROOF OF CLAIM FOR DISABILITY BENEFITS

IMPORTANT: USE THIS FORM ONLY WHEN THE CLAIMANT BECOMES SICK OR DISABLED WHILE EMPLOYED OR BECOMES SICK OR DISABLED WITHIN FOUR (4) WEEKS AFTER TERMINATION OF EMPLOYMENT. OTHERWISE USE GREEN CLAIM FORM DB-300.

PART B - HEALTH CARE PROVIDERS STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY AND THE FORM MAILED TO THE INSURANCE CARRIER OR SELF-INSURED EMPLOYER, OR RETURNED TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF THE RECEIPT OF THE FORM. For item 7d, give approximate date. Make some estimate. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date under "Remarks".

1. Claimant's Name Beatrizia Weiss 2. Age 2 3. Sex  Male  Female  
4. Diagnosis/Analysis Left Ankle Fracture Diagnosis Code \_\_\_\_\_

5. Claimant's Symptoms \_\_\_\_\_

6. Objective Findings \_\_\_\_\_

7. Claimant Hospitalized  Yes  No From ORTF Ankle To \_\_\_\_\_ b. Date \_\_\_\_\_

8. Operation Indicated  Yes  No a. Type \_\_\_\_\_ b. Date \_\_\_\_\_

9. Enter dates for the following:

MONTH	DAY	YEAR
8	27	2013
9	12	2013
12	15	2013

a. Date of your first treatment for this disability \_\_\_\_\_  
b. Date of your most recent treatment for this disability \_\_\_\_\_  
c. Date claimant was unable to work because of this disability \_\_\_\_\_  
d. Date claimant will be able to perform usual work \_\_\_\_\_  
8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease  Yes  No  
If "Yes", has form C-4 been filed with the Workers' Compensation Board  Yes  No  
Remarks (attach additional sheet, if necessary) \_\_\_\_\_

I affirm that  Chiropractor  Physician  Psychologist  Podiatrist  Nurse - Midwife  
I am a  Dentist  Podiatrist  Nurse - Midwife  
Licensed in the State of New York License Number 245955

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD PRESENTS, CAUSES TO BE PRESENTED, OR PREPARES WITH KNOWLEDGE OR BELIEF THAT IT WILL BE PRESENTED TO OR BY AN INSURER, OR SELF-INSURER, ANY INFORMATION CONTAINING ANY FALSE MATERIAL STATEMENT OR CONCEALS ANY MATERIAL FACT SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.

Health Care Provider's Signature [Signature] Date 9/12/13  
Health Care Provider's Name (Please Print) Louis Amora Tel. No. 914-789-2700

Office Address [Address] Zip or Zip+4 [Zip] SS Code [Code]  
HIPAA NOTICE - In order to expedite a worker's compensation claim, WCL 13-46(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Employer's Name Prime Security Employer's Statement [Statement] Policy Number 968628  
Employer's Address 46 Main Suite 331 Telephone Number 845 356-0078

Employee's Name and Address Azizian Weiss 2 Zilmer St Spring Valley NY 10977  
Was the employee provided with the Statement of Rights (Form DB271S)  Yes  No If "Yes", date 8/12/13  
Is Employee a  Member  Owner  Partner  Spouse  Full-time Worker  Part-time Worker  Social Security Number ORFIC

Date of Employment June 10/3 Normal Work Week (Check boxes to show usual days worked)  Sun.  Mon.  Tues.  Wed.  Thurs.  Fri.  Sat.  
Date Employee Last Worked Aug. 23, 2013 Date Employee Wages Ceased Aug. 22, 2013

Has Employee returned to work  Yes  No If "Yes", date \_\_\_\_\_  
Has employment terminated  Yes  No If "Yes", why \_\_\_\_\_  
Are wages being continued during disability \_\_\_\_\_ Yes  No   
If "Yes", does Employer request reimbursement \_\_\_\_\_ Yes  No   
Was Employee on job when disability occurred \_\_\_\_\_ Yes  No   
Has claim been filed for Workers' Compensation \_\_\_\_\_ Yes  No   
Name of Workers' Compensation carrier STATEN IS. COMPANY Yes  No   
Is Employee member of a union that provides for payment of weekly cash benefits  Yes  No  
If "Yes", give name, address and telephone number of union \_\_\_\_\_

Does Employee contribute to cost of this insurance \_\_\_\_\_ Yes  No   
If "Yes", is employee contribution the maximum permitted by law  Yes  No Other \$ \_\_\_\_\_  
Employer tax ID 13-1635 Signed [Signature] Title \_\_\_\_\_  
THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES