



Northeastern Health System*1400 East Downing*PO Box 1008*Tahlequah, OK
74465*918-456-0641

Dear Patient,

Northeastern Health System realizes that hospital bills are often unexpected and can create a financial hardship. Enclosed is an application to determine if you are eligible for Financial Assistance.

Please **complete and return the application** along with the **requested documentation** within 10 days. You must **completely fill out the form**, as well as **sign and date** it. You must submit proof of your income. If your form is not complete and we cannot verify your income, you cannot be considered for Financial Assistance.

Future accounts are not automatically qualified under Financial Assistance. Physician's charges are not considered for Financial Assistance.

If you have any further questions regarding this issue, please contact the Patient Financial Counselor.

Sincerely,

Patient Financial Counselor
(918) 453-2212
(918) 453-2341 fax

1400 E Downing
Tahlequah, OK 74465



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FINANCIAL ASSISTANCE PLAIN LANGUAGE SUMMARY

Northeastern Health System is committed to providing emergency or other non-elective medically necessary care to all patients living in our service area. Providing health care to those who cannot afford to pay is part of our mission. You may qualify for free or discounted care based on family size and income, even if you have health insurance.

If you think you may have trouble paying for your health care, please talk with us. When possible, we encourage you to ask for financial help before receiving medical treatment.

What is covered? For emergency and other non-elective medically necessary care at Northeastern Health System, we provide free care and financial assistance to eligible patients on a sliding fee scale basis, with discounts ranging from 100 to Medical Allowable rates. Patients eligible for financial assistance will not be charged more than amounts generally billed (AGB) to patients who have insurance.

How to Apply: Any patient may apply to receive financial assistance by submitting an application and providing supporting documentation. If you have questions, need help, or would like to receive an application form or more information, please contact us:

- By telephone: 918-453-2262
- On our website at: <https://www.alwaysnhs.org/patients>
- In person: Patient Financial Counseling Department/Billing Office
- To obtain documents via mail free of charge: Financial Counseling Department, Northeastern Health System, 1400 E Downing, Tahlequah, OK 74464

If English is Not Your First Language: Spanish version of the application form is available upon request.

Other Assistance:

Coverage assistance: You may be eligible for other government programs. We can help you learn whether these programs (including Medicaid) can help cover your medical bills and help you apply for these programs.

Payment plans: Any balance for amount owed by you is due within 20 days. The balance can be paid in any of the following ways: credit card, payment plan, cash or check. If you need a payment plan, please call 918-453-2262 or 918-956-0201.

Emergency care: Northeastern Health System has a dedicated emergency department and provides care for emergency medical conditions (as defined by the Emergency Medical Treatment and Labor Act) without discrimination consistent with available capabilities, without regard to whether or not a patient has the ability to pay or is eligible for financial assistance.

Thank you for trusting us with your care.



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YOU MAY BE ELIGIBLE TO RECEIVE FREE OR DISCOUNTED CARE. Completing this application will help Northeastern Health System determine if you may receive free or discount services or are eligible for other public programs that may help you pay for your health care.

INSTRUCTIONS FOR COMPLETING THIS FORM:

Please fill this form out completely and return with all required documents. Financial assistance will not be awarded to those who do not complete the application process, including the requirement for the patient to apply for programs for which they may qualify (i.e. Medicaid).

Please submit this application with the following documentation:

1. Copies of your current federal tax return with all schedules, (including W-2s) or Proof of Non Filing (IRS Form 4506)
2. Household income verification as required below in the "Household Monthly Income: section
3. Proof of Medicaid denial, if eligible –apply at <http://www.okhca.org/individuals.aspx> (online Enrollment)

PATIENT NAME	DATE OF BIRTH	ACCOUNT #
Responsible Party/Guarantor name	Date of Birth	Social Security Number
Relationship to Patient	Home Phone	Cell Phone
Current Address	Own/Rent?	City, State, Zip
Employer Name/Address		Work Phone
Spouse name	Date of Birth	Social Security Number
Employer Nae/Address	Work Phone	Cell Phone

Additional Household Members					
Name	Date of Birth	Relationship	Name	Date of Birth	Relationship

Other Information

1. Does your employer (or spouse's employer offer group health insurance? Y/N If Y, list insurance company below
 2. Do you have other types of insurance that may pay medical bills? Y/N if Y, list insurance company below
 3. Do you have a Health Savings/Flex Spending Account? Y/N if Y, what is the balance amount \$ _____
 4. Does your employer reimburse you for any deductible or healthcare costs? Y/N
 5. Were you denied for Medicaid? Y/N If Y, please attach copy of Medicaid denial
 6. Are you eligible for COBRA through a previous employer? Y/N If Y, list insurance company below
 7. Was the patient involve in an alleged accident that led to the need for services?
 8. Was the patient a victim of an alleged crime that led to the need for services?
- _____
- _____
- _____
- _____

Household Monthly Income			
Type	Responsible Party	Spouse	Type of Income Verification Required
Employment Income (Gross Self Employment Income (Gross)	\$	\$	Provide paycheck stubs for the last two pay periods or 3 months of bank
Pension, Retirement, Social Security Income	\$	\$	



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Unemployment, Disability Income	\$	\$	
Child Support, Alimony	\$	\$	
Other (please list source)	\$	\$	

Assets		
Type	Financial Institution	Total Balance (approximate as accurately as possible)
Cash		\$
Checking Account(s)*		\$
Savings Account(s)*		\$
Stocks or Bonds*		\$

*Provide 3 months bank statements of Stock/Bonds statements

Please explain any situation we should be informed of in order to understand your inability to pay the medical balance. You may attach a separate sheet if more space is needed. Additional verification may be required.

I hereby state that the information given herein is true and correct. I authorize any required verification, including a credit bureau report. I understand that if this information is determined to be false, or deceptive, I will be liable for payment of charges for all services rendered. I understand that this request for financial assistance may not pertain to other health care providers.

Responsible Party Signature _____ Date: _____

NHS CBO USE ONLY

Checklist of required information of complete application process:

- Front and back of form completely filled out with signature and date
- Copies of current federal tax return with all schedules including W-2s (or Proof of non-filing-IRS Form 4506)
- Items required in Household Income Verification section

Date All Items Received by Northeastern Health System Central Business Office _____

NHS CBO Representative _____

Date Final Application Reviewed: _____ By: _____

Level of Approved Financial Assistance for Non-elective Medically Necessary Services: _____

Date Range of Approval: _____

Financial Assistance Denied: _____



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Denial Reason: _____

Notifications Sent:

Patient _____

Solutions _____

Hospitalists _____

AMS _____

ER Physicians _____

Other _____

NORTHEASTERN HEALTH SYSTEM
COLLECTION POLICY SUMMARY

Thank you for allowing us to be the provider of your health care needs. Patient Financial Counselors are available during business hours to answer your insurance coverage and billing questions. Please call (918)453-2262 for more information.

Following is an outline of our Collection Policy and what your financial responsibilities will be.

INSURANCE VERIFICATION AND CLAIM FILING

- It is your responsibility to give us accurate insurance and demographic information prior to or at the time services are provided
- We will file insurance claims that are assigned to the organization with adequate proof of coverage. You may be asked to assist in the follow-up processes that have been required by your insurance company to pay your claim.
- While filing of insurance claims is a courtesy we're happy to extend to you, all charges are the patient's/guarantor's responsibility from the date services are rendered
- It is your responsibility to understand your insurance coverage limits and benefits.

BILLING

- After insurance pays on your account, you will receive a statement for your portion of the services not paid for by the insurance company. Payment will be due within 30 days unless prior arrangements have been made
- In the event your insurance company does not pay after multiple requests for payment, you will be responsible for the bill

PAYMENT

- Insured patients will be asked to pay their insurance co-pay and/or deductible upon registration
- or prior to discharge
- Non-scheduled, uninsured patients may make payment arrangements by calling (918) 453-2262 or (918)956-0201
- Scheduled patients will be contacted by the central scheduling Department for payment arrangements. You may also contact them by calling (918) 453-2262 or (918)956-0201.
- We accept cash, check, VISA, Discover and MasterCard for payment purposes
- If you think you may have trouble paying for your health care, please contact us at(918) 453-2262 or (918)956-0201. You may qualify for free or discounted emergency or other non-elective medically necessary care based on family size and income.
- We will not engage in Extraordinary collection Actions before reasonable efforts are made to determine whether you are eligible for assistance under the Financial Assistance Policy.



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Extraordinary Collection Actions are defined as those requiring a legal or judicial process (except for Accident liens), involve selling debt to another party or reporting adverse information to credit agencies or bureaus. Please see the Financial Assistance Policy for more details

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Title:	Financial Assistance Policy	Next Periodic Review:	
		Owner:	
Northeastern Health System, d/b/a/ NHS Health policies apply to Northeastern Hospital, (all other entities and Supply)			

POLICY:

It is the policy of NHS to provide emergency or other non-elective medically necessary care to all patients living in our service area, without regard to the patient's financial ability to pay for services provided.

The purpose of this policy is to outline the circumstances under which NHS will provide free or discounted care to patients who are unable to pay for emergency or other non-elective medically necessary services and how Northeastern Health System will calculate amounts charged to those patients.

Non-elective medically necessary services are defined as a medical condition that, without immediate attention:

- Places the health of the individual in serious, jeopardy, as defined by a physician
- Causes serious impairment to bodily functions or serious dysfunction to a bodily organ, as defined by a physician

Patient types assumed to be covered by this definition include, but are not limited to:

- Emergency Department ER Level 4 & ER Level 5 outpatients; ER Level 3 is based on Diagnosis
- Emergency Department ER Level 4 & ER Level 5 Admissions; ER Level 3 is based on Diagnosis
- Inpatient/Outpatient follow-up related to the previous Emergency visit
- Care management of chronic severe illnesses, ex. Diabetes Mellitus, COPD` etc.

PROCEDURE:

Upon registration, and after all EMTALA requirements are met, hospital patients without Medicare, Medicaid, third-party insurance, other local health care financial assistance or



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adequate health insurance shall receive financial counseling assistance from NHS staff, including a packet of information that addresses the financial assistance policy and procedures and an application for financial assistance (if requested).

Patients requesting financial assistance will be required to complete the Financial Assistance Application Form, in order to establish eligibility (see attached Exhibit). In certain situations, the application process may be initiated by NHS. Requests for financial assistance will be honored up to 120 days after the date the first post-discharge billing statement is sent to the individual either by mail or electronic bill presentment.

It is the patient/guarantor's responsibility to provide, to the best of their knowledge, accurate, honest and complete information regarding their application and billing information. The patient/guarantor shall be required to provide information and verification of ineligibility for benefits available from insurance, Medicare, Medicaid, Workers Compensation, third-party liability (e.g. auto accident or personal injury) and other programs.

All available financial resources shall be evaluated before determining financial assistance eligibility. NHS will consider financial resources not only of the patient and other members of the household, but also of other persons having legal responsibility to provide for the patient.

The financial assistance assessment methodology shall consider income of the patient/guarantor/household, assets, family size, historical financial profile, current available resources and the likelihood of future earnings sufficient to pay for health care services (See Eligibility Criteria/Basis for Calculating Amounts Charged to Patients below).

Presumptive Eligibility:

Individuals who are uninsured may be considered eligible for the most generous financial assistance in the absence of a completed Financial Assistance Application (FAA) if:

- Individual is homeless
- Individual is deceased and has no known estate able to pay hospital debts
- Individual is incarcerated for a felony (verified on OSCN.net website)
- Individual has received Medicaid benefits. Service dates for up to one year prior to the



Medicaid qualification and six months past the Medicaid eligibility date will be considered for Financial Assistance.

A credit report may be generated for the purpose of identifying additional expense, obligations

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and income to assist in developing a full understanding of the individual's financial circumstances. A third party scoring tool may be used to justify financial assistance eligibility. In the event household size is not indicated on the credit report or third party scoring tool. NHS will use the demographic information provided by the patient/guarantor at time of admission. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the presumptive eligibility and will extend an additional six months into the future.

For any individual presumed to be eligible for financial assistance in accordance with this policy, the same actions described in the Section and throughout this policy would apply as if the individual had submitted a completed a Financial Assistance Application.

Approved Financial Assistance:

Patients/Guarantors will be notified by U. S. mail when NHS determines the amount of financial assistance discount eligibility related to emergency or other non-elective medically necessary services provided by NHS. This eligibility does not extend to services provided by non-facility employees or other independent contractors (physicians, physician practices, anesthesiologists, radiologists, pathologists, etc.) unless noted in the attached Addendum that the provider is participating in this policy. Financial assistance adjustments will be applied to dates of service for emergency or other non-elective medically necessary services for up to one year prior to the application approval and will extend an additional six months into the future. After that, a new verification of financial status shall be required to continue financial assistance discounts. Accounts will be adjusted at the time the Financial Assistance is approved.

Denied Financial Assistance:

Patients/Guarantors will be notified by U. S. mail if financial assistance is denied along with a brief explanation of the reason for the determination.

Eligibility Criteria/Basis for Calculating Amounts Charged to Eligible Patients:

Charges for emergency or other non-elective medically necessary care provided to patients eligible for financial assistance under the policy will be limited to not more than the amounts



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generally billed (AGB) to those individuals who have insurance. Charges, as defined in this policy, are considered the amount the patient is personally responsible for paying, after all deductions, discounts and insurance reimbursements have been applied. Discounts under this policy will be applied according to the following sliding scale:

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Annual Household Income Amount of Discount for Uninsured:

Annual Household Income	Amount of Discount
Up to 100% of FPG	100%
101-150% of FPG	75%
151-300% of FPG	Account reduced to Medicare Allowable

Actions under Billing and Collection Policy in the Event of Non-Payment:

NHS will not engage in extraordinary collection actions (ECA) for up to 120 days after the date of the patient's first statement. During that time, NHS will make reasonable efforts to determine whether an individual who has an unpaid amount from NHS is eligible for financial assistance.

Extraordinary collection actions include:

- Reporting a patient's delinquent debt to a credit bureau
- Selling a patient's debt to a third party
- Placing a lien on a patient's real property
- Attaching or seizing a patient's bank account or other personal property
- Commencing a civil action against a patient
- Causing a patient's arrest due to the debt
- Garnishing a patient's wages

NHS will publicize the availability of financial assistance (see next section). Also, notices will be printed on statements to the patient/guarantor, directing the patient/guarantor to



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contact the Northeastern Health System Business Office to discuss financial arrangements and the availability of financial assistance.

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Also, the patient/guarantor will be sent a written notice 30 days after the initial statement that extraordinary collection efforts (ECA) may be initiated if a complete financial assistance application is not submitted, the bill is not paid, or an arrangement to pay the bill has not been agreed to by both patient and provider within 120 days after the first billing statement. Although NHS may undertake ECAs after this 120 day period, if we have not yet determined whether an individual is FAP-eligible, we will still accept and process an FAP application for an additional 120 days. The total period during which NHS must accept and process FAP application is 120 days from the date of the first billing statement. If NHS receives an FAP application during the application period, we will suspend any ECAs we have started until we have processed the application and made a determination of eligibility. If the individual is FAP-eligible, we will reverse the ECAs. While debts may be referred to third parties to assist with collection actions at any time, including during the Initial 120 day notification period, they will not be sold to third parties during the notification period unless and until an eligibility determination has been made.

Publicizing the Availability of Financial Assistance:

- NHS will post complete and current versions of the following on the NHS website:

- Financial Assistance policy (FAP)
- Financial Assistance Application Form (FAA)
- Plain Language Summary of the Financial Assistance Policy (PLS)
- Contact information for NHS Financial Counselors



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- Signs will be posted in English to advise patients of the availability of financial assistance. Signage will be displayed in all points of admission and will contain the following,

- Northeastern Health System website address where the FAP, FAA, and PLS may be accessed <https://alwaysnhs.org/patients>

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- Telephone number and physical location that individuals may call or visit to obtain copies of the FAP, FAA and PLS or to obtain more information:
 - Patient Financial Department/Central Business Office at Northeastern Health System (918)453-2262
 - Signage, the FAP, FAA and PLS will be in other languages in instances where the lesser of 1,000 individuals or 5% or more of the local population speaks said foreign language.
- Paper copies of this information will be available upon request at all points of admissions.
- A notice will be included on billing statements that notifies and informs recipients about the availability of financial assistance for eligible individuals under NHS's FAP and includes the telephone number of the Financial Counselor who can provide information about the FAP and application process and the website address where copies of the FAP, FAA and PLS may be obtained.
- NHS will distribute Financial Assistance information at Community Health Fairs.

What Do I Need to Submit Based on Your Work Status?

Please provide copies of documents, **based on individuals work status** for the following household members: **Patient and anyone with an income or unemployment status that may help provide for you.** **All documents listed under the work status is needed unless you do not receive it.**

Are you Employed or Self-employed?

1. Pay Stubs from the last 2 months
2. Copy of previous year's complete Tax Returns
3. 2 months of COMPLETE bank statements (document must include utility payments and rent/mortgage payments. If, payments are not on the bank statement, 2 months of copies of the utility/rent/mortgage payments are needed).
 - ❖ If Self-Employed please submit 4 months of COMPLETE bank statements
4. Any governmental assistance documentation (SNAP/Food Stamps, Gov't Housing)
5. Include the above for any income holder within the household (Pay Stubs, Social Security Award Letter, Pension Benefits Statement, 2 months of bank statements, previous year tax forms)

Are you Disabled or Retired?

1. Social Security and/or Pension Benefit Statements or letter from current year
2. 2 months of COMPLETE bank statements (document must include utility payments and rent/mortgage payments. If, payments are not on the bank statement, 2 months of copies of the utility/rent/mortgage payments are needed).
3. Notarized Income Verification Letter if you're supported by another's income (see page 4)
4. Any governmental assistance documentation (SNAP/Food Stamps, Gov't Housing)
5. Include the above for any income holder within the household (Pay Stubs, Social Security Award Letter, Pension Benefits Statement, 2 months of bank statements, previous year tax forms)

Are you Unemployed?

1. Unemployment letter, denied or approved, if you were issued one
2. Notarized Income Verification Letter if you're supported by another's income (see page 4)
3. Copy of previous year's complete Tax Returns



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4. 2 months of COMPLETE bank statements (document must include utility payments and rent/mortgage payments. If, payments are not on the bank statement, 2 months of copies of the utility/rent/mortgage payments are needed).
5. Any governmental assistance documentation (SNAP/Food Stamps, Gov't Housing)
6. Include the above for any income holder within the household (Pay Stubs, Social Security Award Letter, Pension Benefits Statement, 2 months of bank statements, previous year tax forms)

Are you a Full-Time Student?

1. Copy of Award Letter and Transaction Ledger for loans and/or grants
2. 2 months of COMPLETE bank statements (document must include utility payments and rent/mortgage payments. If, payments are not on the bank statement, 2 months of copies of the utility/rent/mortgage payments are needed).
3. If applicable- any governmental assistance documentation (SNAP/Food Stamps, Gov't Housing)

Income Verification Letter: Proceed only if you are unemployed!!!

If you and/or your spouse are employed, you may disregard this page of the application.

This form needs to be completed only for applicants with no employment income. Please have someone who knows you complete any/all applicable fields of this form.

This form must be signed in the presence of the Patient Financial Counselor
OR
you may choose to have it notarized.

1. I certify that _____ is presently unemployed and he/she is living with me and pays no rent.
2. I certify that _____ is presently unemployed and I pay his/her living expenses.
3. I have known _____ for _____ years and I certify that he/she is unemployed and has no income.

Relationship to patient: _____

Printed Name: _____

Phone #: _____



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Address: _____

City, State: _____ Zip: _____

❖ Signature: _____ Date _____

For Notary or Financial Counselor: (Due to COVID notary is not required at this time)

Signed before me this _____ day of _____ 2021

My commission expires: _____ Signature _____