Connection Fee Assistance Program - EHR/EMR Vendor Expense Application

Date		**Submitted By**	
Phone Number		**Email Address**	
Practice Name			

PRACTICE NAME AS INCLUDED ON THE OKSHINE CONNECTION FEE APPLICATION

Contact Name	
Contact Title	
Number of providers in the Organization/Practice?	
EMR Vendor / Product / Version #	

Connection Fee ID *IF APPLICABLE*

Is EMR Certified? ☐ **Yes** ☐ **No** *MARK ONE*

Provide EMR Vendor Cost

FOR EACH CONNECTION TYPE, IF APPLICABLE

ADT	**$**	**ORU**	**$**	**VXU**	**$**	**PRE**	**$**
CCD	**$**	**ORM**	**$**	**MDM**	**$**	**SSO**	**$**

Does the cost listed above cover all providers in the Organization/Practice? ☐ **Yes** ☐ **No**

IF NO, PROVIDE THE TOTAL COST TO COVER ALL PROVIDERS WITHIN THE ORGANIZATION/PRACTICE BELOW *MARK ONE*

One-Time Total Cost **$**

Ongoing/Recurring Total Cost* **$**

*Applicant acknowledges and accepts that any ongoing/recurring costs are the responsibility of the Practice and will not be covered by the connection fee application funds.

☐ **Yes** ☐ **No**

MARK ONE

NOTES

EMR Vendor Quote: This form must include a quote from the EMR Vendor that clearly identifies whether the pricing is for each provider within the Organization/Practice or for all providers within the Organization/Practice.

Reimbursement Conditions: By submitting this form, the organization understands that reimbursement will not take place until confirmation of at least a live HL-7 V2.x ADT and CCDA feed, both meeting the minimum specifications as detailed on the Oklahoma Health Care Authority OKSHINE website (https://okshine.oklahoma.gov/).

One-Time Payment: By submitting this form, the organization understands that this is a one-time payment and does not include any ongoing or recurring fees associated with this integration.

Reimbursement Process: MyHealth will reimburse the Organization/Practice for payment to their EMR vendor based on the paid invoice submission aligned with the OHCA-approved amount.

Required Documentation: Vendor invoice, proof of payment by the Organization/Practice, and proof of reimbursement from MyHealth will be needed for invoicing.

Organization Signature	
Printed Name	
Title	

Signature	Date

Thank you for taking the time to complete this form—your input is greatly appreciated. Once finished, please submit the completed form to MyHealth@myhealthaccess.net. Your portion is now complete, and our team will take care of the remaining sections internally. If we need any additional information, we'll be in touch.

Thanks again!

Reviewed by MyHealth Director of Client Services	
Printed Name	
Title	

Signature	Date

Office of the Coordinator for Health Information Exchange Review	
Printed Name	
Title	

Signature	Date

Approval Status ☐ **Approved** ☐ **Denied**

Notes