Financial Assistance

North Jefferson County Ambulance District offers financial assistance to make healthcare affordable and accessible to members of the community. We also provide discounted and charity care for eligible individuals. If payment of your healthcare expenses could create a financial hardship for you, you may qualify for financial assistance.

Am I eligible?

- Household income, in relation to federal poverty guidelines
- Any additional financial hardship
- Medically necessary care
- The account must be a current, non-collection referred account

How do I apply?

Complete the financial assistance application. Along with the application, you must submit **all** of the following documents that apply to you and your household;

- Copies of most recent Federal Income Tax Return for each household member(s)
- Copies of most recent W-2's for each household member(s)
- Copies of the 3 most recent paycheck stubs or a statement of earnings from each household member(s) employer
- Copies of unemployment and/or disability compensation statements for each household member(s)
- Copies of Social Security or pension income for each household member(s)
- Copies of government assistance notices, such as Social Security Disability and Medicaid Programs for each household member(s)

Where do I send my completed application & documentation to?

Your application and documentation can be sent the following ways;

- Mail

  North Jefferson County Ambulance District
  3131 Rock Creek Rd
  High Ridge, MO 63049

- Secured Fax

  (636) 671-9885

- Email

  billing@njcad.com

North Jefferson County Ambulance District
Financial Assistance Application

Email the completed application along with all documents to billing@njcad.com.
For questions, please contact Patient Accounts at 636-677-3399 Ext. 1.

What is the date of service this application is pertaining to? MM/DD/YYYY

Patient Information

Last Name	First Name	Middle Initial	Social Security #	Date of Birth
				MM/DD/YYYY
Street Address	City	State	Zip Code	
Mailing Address	City	State	Zip Code	
Home Phone # ( ) -	Mobile Phone # ( ) -	Check one: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		

Responsible Party Information
(If Different from Patient)

Last Name	First Name	Middle Initial	Relationship to Patient	Social Security #
Address (if Different from Patient)			Home Phone # ( ) -	Mobile Phone # ( ) -
Name of Insurance Company			Effective Date	MM/DD/YYYY

Please indicate ALL people living in the household, including Applicant
(Use additional sheet of paper if needed.)

First & Last Name of ALL Individuals Residing in the home with the Patient	Relationship to Patient	Date of Birth	Social Security #
1.		MM/DD/YYYY	
2.		MM/DD/YYYY	
3.		MM/DD/YYYY	
4.		MM/DD/YYYY	
5.		MM/DD/YYYY	
6.		MM/DD/YYYY	

Household Miscellaneous Questions

Has anyone in your household applied for NH Healthy Kids or Medicaid? ☐ Yes ☐ No			
Who	When	Reason	What is the status? ☐ Pending ☐ Denied
Is anyone in your household pregnant? ☐ Yes ☐ No			
Has anyone in your household served in the military? ☐ Yes ☐ No			Who?
Have you recently filed a worker's compensation or motor vehicle accident claim? ☐ Yes ☐ No			MM/DD/YYYY
Is anyone in your household eligible for Social Security benefits? ☐ Yes ☐ No			Who?
Is anyone in your household covered by health insurance or a health savings account (HSA)? ☐ Yes ☐ No			
Does anyone else claim you on their income tax return? ☐ Yes ☐ No			Who?

Household Information

	Patient	Spouse/Significate Other/Roommate	Dependent	Dependent
Name of each household member				
Name of employer				
Monthly Income				
Employment	$	$	$	$
Self-Employment	$	$	$	$
Investment Accounts	$	$	$	$
Real Estate Rentals	$	$	$	$
Unemployment (since MM/DD/YYYY)	$	$	$	$
Retirement (Soc. Security, Pension, Annuity)	$	$	$	$
Alimony/Child Support	$	$	$	$
Public Assistance, Food Stamps	$	$	$	$
Other Income	$	$	$	$
Savings and Investments				
Checking Account Balances	$	$	$	$
Savings/CD Account Balances	$	$	$	$
IRA, 403b, 401k Specify:	$	$	$	$
Other savings & Investments Specify:	$	$	$	$

Household Assets & Monthly Expenses

Value of Automobile	$	$	$	$	
What is the Year, Make, Model?					
Value of Recreation Vehicle	$	$	$	$	
What is the Year, Make, Model?					
Rent Payment: $	Mortgage Payment: $			Mortgage Loan Balance: $	
Property Tax Amount Not Included in Payment Amount Above: $				Value of Home: $	
Do you own property other than primary residence? ☐ Yes ☐ No				If Yes, what is the value? $	
Monthly Loan Payment: $	Paid to:			For:	
Medicare Part D deducted from Social Security check: ☐ Yes ☐ No				Amount: $	
Household Utilities	$	Insurance (Auto/Life/Property)	$	Other:	$
Living (Gas, Food, Clothes)	$	Health Insurance Premiums	$	Other:	$
Child Care	$	Medical Bills	$	Other:	$
Alimony/Child Support	$	Medications	$	Other:	$

Assignment of Rights

- By signing below, I authorize the request for my credit report and/or tax return. I understand that a tax return is needed to process this application and that more information may be requested before my eligibility can be determined.
- By signing below, I certify that all information I have submitted is true. I understand that any incorrect, incomplete, or false information that I provide or someone else provides for me could cancel my application for financial assistance.
- All adult household members who sign below authorize the release of any medical, financial or employment information which relates directly to their health care or to their financial assistance eligibility. This information may be released to any health care providers from whom household members have sought health care services or financial assistance. All information provided will remain confidential under the provisions of HIPAA federal regulations. Elective procedures may not be considered for assistance.
- I agree that I will repay the full financial assistance award if I receive payment of any kind for the medical services covered by this application, for example insurance payments, government program payments, award from a lawsuit or any other payment.
- If I receive Financial Assistance, I agree to tell the organization where I first applied of any changes which could impact eligibility, including changes to family size, income and health insurance coverage. I understand that if my/our medical situation changes so that I/we might be eligible for a public assistance program, I will need to apply to that program and provide proof of application.

Applicant Signature _____ MM/DD/YYYY Date

Co-Applicant Signature _____ MM/DD/YYYY Date