JOHNSON COUNTY AMBULANCE SERVICE
EST. 1966

808 S. Dubuque Street
Iowa City, IA 52240
www.johnsoncountyiowa.gov
Business: (319) 356-6013
Fax: (319) 351-0695

PATIENT QUESTIONNAIRE FOR FINANCIAL HARDSHIP DETERMINATION

This application will not be processed without supporting documentation

Please complete this form and return it to Johnson County Ambulance Service or email us at JCASclaims@johnsoncountyiowa.gov

Patient Name: _____

Address: _____

City/State/Zip Code: _____

Phone Number: _____

Responsible Party (if different than patient): _____

Address of Responsible Party: _____

Number of Dependents in Household (including yourself): _____

Insurance Name and Address: _____

Policy Holder Name and Date of Birth: _____

Insurance ID: _____

I am applying for Hardship Determination in order that you will consider waiving my co-pay/co-insurance/deductible (or total charges if uninsured) for service and care provided to me on _____ (date of service).

I am supplying the above information so that you can make an accurate determination of my case. The monthly dollar amount provided is from all sources including Social Security benefits, pensions, annuities, dividends, etc. Attached you will find verification of my employment/unemployment status, copies of my federal tax return or W-2 forms from the previous year.

Monthly Income	**Self**	**Spouse**
Wage/Salary	$ _____	$ _____
Social Security	$ _____	$ _____
Pension	$ _____	$ _____
Other	$ _____	$ _____
Totals	$ _____	$ _____

Statement of Agreement: "I am supplying this information to request that Johnson County Ambulance waive collection of all or part of the deductible or co-insurance amounts due to financial hardship. I also understand that, Johnson County Ambulance can and will collect charges should my financial situation improve, I agree to be responsible if any balance is remaining, after the application of the waiver by Johnson County Ambulance."

Patient/Responsible Party Signature: _____ Date: _____

Updated 8/27/2026