ST. JOSEPH'S HEALTHCARE SYSTEM
703 MAIN STREET
Paterson, NJ

SELF PAY FINANCIAL ASSISTANCE AFFIDAVIT

Patient Name / Nombre del paciente: _____ ECD/Account #:_____
Address / Dirección:_____
Phone / Teléfono:_____

Guarantor Name / Nombre:_____
Guarantor Address / Direccion:_____
Guarantor Telephone # / Teléfono #: _____

The above Patient does not have any medical insurance and his /her family gross income does not exceed 300% of the U.S. Department of Health and Human Services Federal Poverty Guideline noted below.

El paciente no tiene seguro médico y su ingreso bruto de su familia no supere el 300% del Departamento de Salud y Servicios Humanos de los EE.UU. De acuerdo al guia Federal de Pobreza.

Patients with family gross income less 300% of the Federal Poverty Guidline should first apply for the New Jersey Hospital Care Payment Assistance Program.

Los pacientes con ingreso bruto familiar de menos del 300% del nivel federal de pobreza deben primero solicitar el Programa de asistencia de hospitalizs de Nueva Jersey .

Please circle the approriate family size.

Por favor circule el tamaño apropiado de la familia.

Family Size	Federal Poverty Guideline*	300% Federal Poverty Guidline
1	$ 12,760	$ 38,280
2	$ 17,240	$ 51,720
3	$ 21,720	$ 65,160
4	$ 26,200	$ 78,600
5	$ 30,680	$ 92,040
6	$ 35,160	$ 105,480
7	$ 39,640	$ 118,920
8	$ 44,120	$ 132,360

Service	AGB%	AGB Discount
Inpatient	18%	82%
Outpatient-Excluding Emergency Services	28%	72%
Emergency Services - Including related ancillary services	22%	78%
Physician Services (as applied to each of Inpatient, Outpatient,and Emergency Services	26%	74%

*-Guidelines applicable to calendar year 2020
*For families/households with more than 8 persons,add $4,180 for each additional person

I certify that the above information is true and correct. I understand that willful misrepresentation of these facts will make me liable for all hospital charges and subject to civil penalties.

Certifico que la información anterior es verdadera y correcta. Yo entiendo que la falsificación deliberada de éstos hechos me hará responsable de todos los gastos del hospital y sujeto a

Please print name / Por favor escriba el nombre: _____ Relationship / Relacion:_____

Signature / Firma:_____ Date / Fecha: _____