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	Service	AGB %	AGB Discount
1	$ 13,590	$ 40,770	Inpatient	17%	83%
2	$ 18,310	$ 54,930			
3	$ 23,030	$ 69,090	Outpatient - Excluding Emergency Services	29%	71%
4	$ 27,750	$ 83,250			
5	$ 32,470	$ 97,410	Emergency Services - Including related ancillary services	16%	84%
6	$ 37,190	$ 111,570			
7	$ 41,910	$ 125,730	Physician Services (as applied to each of Inpatient, Outpatient,and Emergency Services	26%	74%
8	$ 46,630	$ 139,890			

*-Guidelines applicable to calendar year 2022
*For families/households with more than 8 persons,add $4,720 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 sanciones civiles.

Please print name / Por favor escriba el nombre: ________ Relationship / Relacion:_________
Signature / Firma:________________________________ Date / Fecha: ________________