COUNTY OF BERGEN
DEPARTMENT OF HEALTH SERVICES
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James J. Tedesco III
County Executive

Hansel F. Asmar
Director/Health Officer

Bergen County Cancer Education and Early Detection Program

Thank you for your interest in the New Jersey Cancer Education and Early Detection (NJCEED) program.

In order to be eligible for this program you must qualify in **each** of the following three areas:
(1) age/risk factor, **and**
(2) income (<250% of Federal Poverty Level), **and**
(3) no insurance or underinsured

How to apply for our program:
1. Enclosed is a document entitled "Patient Declaration of Income and Insurance" to determine eligibility.
2. Review the application for accuracy and completeness before you sign the "Patient Declaration of Income and Insurance."
3. Please complete (sign and date) the document and return it in the enclosed envelope.

A staff member will call when we receive the application to inform you of your eligiblitiy.

If you have any additional questions about the NJCEED program, please call 201-634-2664 during normal business hours.

Sincerely,

Susan Crandall, RN, BS
Program Coordinator/Case Manager

Patient Declaration of Income and Insurance

Do you have Health Insurance Coverage? (If yes, send copy of card with your application)

No _____ Yes _____ (Please circle type below)

Medicare Ameri Health

Medicaid Blue Cross/Blue Shield

Aetna Any type of Family Care/Charity Care

Other:_____

I, _____, confirm that I do not have health insurance coverage of any type at this time and that the *household income* is _____.
This income supports ___ people of these ages: _____. Therefore as a
(Number) (Ages of all in the household)
resident of New Jersey, according to the New Jersey Department of Health guidelines, I am eligible for cancer screenings under New Jersey Cancer Education and Early Detection (NJCEED) Program.

I attest that the information stated above is true and accurate to the best of my knowledge. I understand that if the above information is misrepresented, it may be grounds for suspension of Program services and that I may be required to pay the total actual cost for the services provided to me under the NJCEED Program.

Signed_____ Date_____

Address _____

Phone Number _____
Email address:_____

Witness_leave blank_____ Date_____