



Charles S. Crane Family Foundation STARS Program
 Providing Student Testing Assistance Referrals and Support

Participating Provider Form

General Information

Name:	
Practice/Employer:	
Address:	
Phone:	
Fax:	
Email:	

Education and Certification(s)

Degree(s) Held:	
Certification:	
Licensing Organization:	
License Number:	

Professional Information

<input type="checkbox"/> Psychologist	<input type="checkbox"/> Physical Therapist	<input type="checkbox"/> Audiologist
<input type="checkbox"/> Neuro-Psychologist	<input type="checkbox"/> Occupational Therapist	<input type="checkbox"/> Physician
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Speech & Language Pathologist	<input type="checkbox"/> Other: _____

Preferred Age Group:	
Specialty:	
Professional Interests:	
Tests Administered:	

Payment Information

Do you accept insurance?	
Accept Medical Assistance?	
Checks Payable to:	
Billing Address:	
Tax ID Number:	

I would like to be on the CJE participating provider list for the STARS program. For qualifying clients (as deemed eligible by the CJE), I agree to accept payment from the CJE for the cost of testing. I understand the CJE will cover only 50% to a maximum of \$1000 after insurance payment of the cost of assessment. The CJE has no further financial obligation beyond the predetermined amount. I understand it is my responsibility to collect the remaining balance from the client.

Signature: _____ Date: _____

Please fax completed forms to 410-735-5001 or mail to:
 CJE, Attn: STARS, 5708 Park Heights Ave, Baltimore, MD 21215