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

| | | |
|---|---|---|
| ☐ Psychologist | ☐ Physical Therapist | ☐ Audiologist |
| ☐ Neuro-Psychologist | ☐ Occupational Therapist | ☐ Physician |
| ☐ Social Worker | ☐ Speech & Language Pathologist | ☐ 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