# NJ Children's System of Care
# Provider Staff List

Agency Name:
Address:
Phone Number for Referrals:
Fax Number for Referrals:
IIC Medicaid #:
IIH/ISS Medicaid #:
Effective date:

| **Provider Name** | **Degree & License** | **Services Provided** *i.e., IIC, IIH, BA, mentor, personal trainer, etc.* | **Areas of Expertise - Indicate Specialty Certificates / Licenses to** | **Preferred Referrals -** *what situations/diagnosis does the individual* | **Areas Served** | **Languages spoken** | **Email & Phone** | **Gender** |
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