Trauma- Focused Cognitive Behavioral Therapy (TF-CBT) Application (2024)

Please complete the application below.

TF-CBT INDIVIDUAL APPLICATION

The TF-CBT online training is scheduled to begin in Fall 2024 with the Center for Evidence to Practice for this training opportunity. The training is limited to 30 practitioners.

The training application requires the following to be completed for EVERY APPLICANT: the TF-CBT application AND the Agency Agreement.

Please review the TF-CBT Request for Applications (RFA) in its entirety for complete details about the training prior to completing an application:

RFA.

SECTION 1- APPLICATION INSTRUCTIONS

(1) The TF-CBT Application is to be completed by each applicant and can be accessed by filling out this online application. **Please note, each TF-CBT Application must upload an Agency Agreement.

This must be completed by SATURDAY, OCTOBER 12, 2024.

(2) The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the TF-CBT training and signed by the Administrator and Supervisor. You can access the AGENCY AGREEMENT by CLICKING HERE. The AGENCY AGREEMENT MUST BE SUBMITTED THROUGH THE TF-CBT APPLICATION. The deadline for completion is SATURDAY, OCTOBER 12, 2024.

BOTH FORMS MUST BE COMPLETED FOR EACH TF-CBT APPLICANT TO BE CONSIDERED FOR THIS TRAINING OPPORTUNITY

When navigating through this application, please only use the PREVIOUS PAGE and NEXT PAGE buttons on the bottom of the screen. DO NOT utilize the backwards or forwards arrow on the webpage.

SECTION 2- AGENCY INFORMATION

(3) Name of Applicant Agency _____

(4) Agency Street Address _____

(5) Agency City _____

(6) Agency State

◯ LA
◯ Other

Other (please specify state using 2 lettered abbreviations):	_____
(7) Agency Zip Code	_____
(8) Agency Mailing Address (if different from Agency Street Address)	_____
(9) Agency NPI (if known)	_____
(10) What type of agency does the applicant primarily work for?	◯ Child Advocacy Center ◯ Human Services District/Authority ◯ Medical Center (Both inpatient and outpatient) ◯ Mental Health Counseling & Therapy Agency ◯ Independent Mental Health Practitioner/ Private Practice ◯ Other
Please specify the agencies.	_____

(11) Can the applicant attend the following training dates?

	Yes I can attend/participate	No I cannot attend/participate _____
Asynchronous Self-Paced Online Training: Eleven (11) hours of a web-based course on your own time by November 8, 2024. This course is accessible once selecting "YES." _____	○	○
MANDATORY Pre-Requisite TF-CBT Assessment Training: October 29, 2024, from 9am-1pm CST.	○	○
TF-CBT Learning Session 1 Online Training: November 12-14, 2024 from 9am-4:30pm CST.	○	○
TF-CBT Learning Session 2 Online Training: February 26-27, 2025 from 9am-4:30pm CST.	○	○
Consultation Calls: Up to twelve (12) hours of MONTHY consultation calls that occur throughout one (1) year.	○	○

SECTION 3- LOUISIANA MEDICAID (ONE OF THE PREREQUISITES TO HAVE YOUR AGENCY'S APPLICATION CONSIDERED FOR THE TF-CBT TRAINING IS ACCEPTING MEDICAID AND ACTIVELY TREATING CHILDREN AND FAMILIES)

(12) Are you a Louisiana Medicaid Provider?
- ◯ Yes
- ◯ No

By selecting "Yes", which MCO plans?
- ☐ Aetna Better Health
- ☐ Amerihealth Caritas of Louisiana
- ☐ Healthy Blue/Anthem
- ☐ Humana Healthy Horizons
- ☐ Louisiana Healthcare Connections
- ☐ Magellan Behavioral Health
- ☐ United Healthcare/Optum

(Please select all that apply.)

By selecting "No," is your agency a Child Advocacy Center?
- ◯ Yes
- ◯ No

If not, please specify what type of entity.

_____

(13) Do you currently see Louisiana Medicaid clients?
- ◯ Yes
- ◯ No

(14) Do you currently see Medicaid clients in a direct clinical mental health practice?
- ◯ Yes
- ◯ No

If yes, do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.

_____

(15) Please list all insurance plans you accept for payment, including Medicare and private health policies.

_____

(16) Are you actively treating children and families?
- ◯ Yes
- ◯ No

This is a requirement in order to participate in this training opportunity, If you select, "No" for this question, we recommend that this training opportunity is not a good fit for you at this time.

If you selected "Yes," please describe.

_____

SECTION 4- TRAINEE DEMOGRAPHIC INFORMATION FORM (THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT)

(17) Applicant First Name:

_____

(18) Applicant Last Name:

_____

(19) Applicant Job Title:

_____

(20) Applicant Phone Number:

_____

(21) Applicant Email Address:

_____

(Please verify that your email address is typed correctly.)

(22) Please select which age range best describes the applicant.

- ◯ 20-24 years old
- ◯ 25-34 years old
- ◯ 35-44 years old
- ◯ 45-54 years old
- ◯ 55-59 years old
- ◯ 60 years or older

(23) Which of the following best describes the applicant?

- ◯ Female
- ◯ Male
- ◯ Prefer not to say
- ◯ Other

Please specify:

_____

(24) Does the applicant consider themselves to be Hispanic, Latino, or of Spanish origin?

- ◯ Yes
- ◯ No

(25) Which of the following best describes the applicant race? Select all that apply.

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Pacific Islander
- ☐ White or Caucasian
- ☐ More than one race
- ☐ None of the above

Please specify the applicant race:

_____

(26) Which of the following region(s) does the applicant provides services to? Check all that apply:

- ☐ Region 1: Jefferson, Orleans, Plaquemines, St. Bernard
- ☐ Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, West Feliciana
- ☐ Region 3: Assumption, Lafourche, St Charles, St. James, St. John, St. Mary, Terrebonne
- ☐ Region 4: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion
- ☐ Region 5: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis
- ☐ Region 6: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn
- ☐ Region 7: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster
- ☐ Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll
- ☐ Region 9: Livingston, St. Helena, St. Tammany, Tangipahoa, Washington
- ☐ Region 10: Jefferson

(27) What is the applicant's employment status with this agency?

- ◯ Full-time
- ◯ Part-time
- ◯ Contract
- ◯ Temporary
- ◯ Other

Please specify: _____

(28) Educational Degrees and year(s) graduated _____

(29) Please select the STATE applicant is licensed to practice in

- ◯ LA
- ◯ Other

Please specify which state utilizing 2 letter state abbreviations: _____

(30) Please select the credential type that best describes the applicant.

- ◯ Counselor
- ◯ Social Worker
- ◯ Psychologist
- ◯ More than one credential type
- ◯ I have another type of credential
- ◯ I do not hold a credential

Please select your Provisional License/ License Type.

- ◯ PLPC
- ◯ LPC
- ◯ LPC-S
- ◯ PLMFT
- ◯ LMFT

Please select your Provisional License/ License Type.

- ◯ CSW
- ◯ RSW
- ◯ LMSW
- ◯ LCSW
- ◯ LCSW-BACS

Please select your Provisional License/ License Type.	◯ PhD ◯ PsyD
I hold the following credential:	_____
I hold the following credentials (please select all that apply):	☐ PLPC ☐ LPC ☐ LPC-S ☐ PLMFT ☐ LMFT ☐ CSW ☐ RSW ☐ LMSW ☐ LCSW ☐ LCSW-BACS ☐ PhD ☐ PsyD ☐ Other
Please specify:	_____
(31) Please enter your LICENSE NUMBER(s) with your respective credential:	_____
(32) Please enter your LICENSE NUMBER(s) with your respective credential:	_____
(33) Please enter your LICENSE NUMBER(s) with your respective credential:	_____
(34) Please enter your LICENSE NUMBER(s) with your respective credential:	_____
(35) Please enter your LICENSE NUMBER(s) with your respective credential:	_____
(36) What is your NPI number?	_____
(37) Please list the language(s) other than English the applicant is fluent in:	_____

SECTION 5- TRAINEE TF-CBT APPLICATION QUESTIONS. THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT.

(38) Describe your experience serving Medicaid children/adolescents and families.
Number of years in clinical work, agency settings, and treatment approaches, etc. Please limit response to 100 words.

_____

(39) Please list any EBP you completed training in, where you were first trained, and your certification status.

_____

(40) Are you currently in training for other EBP certifications?

◯ Yes
◯ No

When will you complete this training? Please be as specific as possible, including month and year of anticipated completion.

_____

What EBP training are you currently in? Select all that apply.

☐ Parent-Child Interaction Therapy (PCIT)
☐ Positive Parenting Program (PPP)
☐ Trauma Focused- Cognitive Behavioral Therapy (TF-CBT)
☐ Eye Movement Desensitization and Reprocessing (EMDR)
☐ Child-Parent Psychotherapy (CPP)
☐ Pre-School PTSD Treatment (PPT)
☐ Youth PTSD Treatment (YPT)
☐ Functional Family Therapy-Child Welfare (FFT-CW)
☐ Homebuilders
☐ Functional Family Therapy (FFT)
☐ Multi-Systemic Therapy (MST)
☐ Other

Please specify:

_____

(41) Describe the geographic area and population served at your agency. Additionally, please mention any unique characteristics of this population.
Please limit response to 100 words.

_____

(42) Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive TF-CBT.
Please limit response to 100 words.

_____

(43) What is your current caseload per week? Can you add/utilize the TF-CBT practice with your current caseload/clients?
Please limit response to 100 words.

_____

(44) Explain how TF-CBT would fit your agency/practice and the community you serve.
Please limit response to 100 words.

_____

The AGENCY AGREEMENT must be completed and signed through Adobe PDF (a fillable PDF) by a supervisor and/or administrator at the agency requesting participation in the TF-CBT training. The agency agreement must be completed by SATURDAY, OCTOBER 12, 2024.

You can click on this link to access the AGENCY AGREEMENT.

PLEASE UPLOAD YOUR SIGNED AND COMPLETED AGENCY AGREEMENT FORM HERE.

IF YOU HAVEN'T ALREADY, CLICK HERE TO ACCESS THE AGENCY AGREEMENT FORM.

(Please upload signed and filled out agency agreement to the right.)

SECTION 6- IMPLEMENTATION SUPPORT

(45) How many people in your agency have been trained in TF-CBT?

_____

(46) If chosen for this opportunity, would your agency leadership be interested in attending a 1-hour TF-CBT implementation discussion BEFORE beginning TF-CBT training with clinicians?

◯ Yes
◯ No

(47) Do you perceive any barriers to implementing this EBP within your agency?

◯ Yes
◯ No

If yes, please explain how. Please limit response to 100 words.

_____

If no, please explain. Please limit response to 100 words.

_____

(48) If chosen for this training opportunity, rate your level of willingness to work with a group of similar providers in a learning community environment?

◯ Very Unlikely
◯ Unlikely
◯ Neutral
◯ Likely
◯ Very Likely

(49) If chosen for this training opportunity, what is the likelihood that you will be able to participate in a focus group for 1-1.5 hours per month?

◯ Very Unlikely
◯ Unlikely
◯ Neutral
◯ Likely
◯ Very Likely

(50) How did you hear about the TF-CBT training opportunity through the Center for Evidence to Practice?

☐ Evidence to Practice (E2P) MailChimp Listserv and/or E2P Direct Email
☐ Director, Supervisor, or Manager
☐ Direct Email Outreach not from E2P
☐ Word of Mouth
☐ Social Media Advertisement
☐ More than one of these options
☐ Other
(Select all that apply.)

Please specify how you heard about this training opportunity:

_____

SECTION 7- TF-CBT APPLICATION CHECKLIST. Please review PRIOR to submitting your application.

(51) The following steps MUST be executed in order for your application to be considered (please review and answer ALL):

	Yes	No _____
(1) (REQUIRED) Please review the Request for Application (RFA) to be aware of training expectations and IMPORTANT DATES. You can access it here, once selecting "YES." _____	○	○
(2) (HIGHLY RECOMMENDED) COMPLETE the Introduction to TF-CBT Online Course through E2P learn so applicants are aware of the training expectations and time commitment. Accessible here, once you have selected "YES." _____	○	○

SECTION 8- TRAINEE CHECKLIST

(52) By applying for the TF-CBT Training Protocol, I understand that, if accepted, I will be expected to complete the following (please review prior to submitting your application, and select ALL):

	Yes	No _____
(1) I attest that I meet ALL of the prerequisites to participate in the TF-CBT training protocol.	○	○
(2) I agree to complete the TF-CBT training protocol in its ENTIRITY.	○	○
(3) I acknowledge my SUPERVISOR has approved my attendance to this training protocol.	○	○
(4) You acknowledge your Program Head/Clinic Manager knows of your participation in the training AND is agreeing to clear time in your schedule to complete the entire TF-CBT training program.	○	○
(5) I acknowledge that I currently have access to Zoom with VIDEOCONFRENCING CAPABILITIES for the purposes of participating in all training days.	○	○

You have reached the end of the 2024 Fall TF-CBT Individual application.

Please review any of your responses on previous pages utilizing the "previous page" button below before submitting your application.

You will need to TYPE IN YOUR E-MAIL ADDRESS in the TEXT BOX on the next page for a PDF copy of your application responses.