2024 Parent Child Interaction Therapy (PCIT) Application

Please complete the application below.

SECTION 1 OF 6- APPLICATION INSTRUCTIONS

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

RFA.

The PCIT online training is scheduled to begin in Spring 2025 with the Center for Evidence to Practice for this training opportunity. The training is limited to twelve (12) practitioners.

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

The PCIT Application is to be completed by each applicant and can be accessed by filling out this online application. **Please note, each PCIT Application must upload an Agency Agreement.

This must be completed by January 18, 2025.

The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the PCIT 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 PCIT APPLICATION. The deadline for completion is January 18, 2025.

BOTH FORMS MUST BE COMPLETED FOR EACH PCIT 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 OF 6 - PCIT APPLICANT INFORMATION

This questionnaire is to be completed separately by each potential participant.

(ONE OF THE PREREQUISITES TO HAVE YOUR AGENCY'S APPLICATION CONSIDERED FOR THE PCIT TRAINING IS ACCEPTING MEDICAID AND ACTIVELY TREATING CHILDREN AND ADOLESCENTS)

Applicant First Name: ______________________________

Applicant Last Name: ______________________________

Applicant Job Title: ______________________________

SAMPLE

Applicant Phone Number:	__________________________________
Applicant Email Address:	__________________________________ (Please verify that your email address is typed correctly.)
What is your NPI number?	__________________________________
What type of agency does the applicant primarily work for?	◯ Child Advocacy Center ◯ Human Services District/Authority ◯ Medical Center (either inpatient or outpatient) ◯ Behavioral Health Service Provider (BHSP), providing Mental Health Rehabilitation services ◯ Independent Mental Health Practitioner/ Private Practice ◯ LMHP Group Practice ◯ Other
	__________________________________ (Please indicate the type of agency you work at)
Please specify the agency type:	◯ Sole practice provider ◯ Agency-based provider ◯ Both (sole practice provider AND agency-based provider)
What is your employment status with this agency?	◯ Full-time ◯ Part-time ◯ Contract ◯ Temporary ◯ Other
Please describe.	____
Are you a Louisiana Medicaid Provider?	◯ Yes ◯ No
Which MCO plans are you contracted with?	☐ Aetna Better Health ☐ Amerihealth Caritas of Louisiana ☐ Healthy Blue/Anthem ☐ Humana Healthy Horizons ☐ Louisiana Healthcare Connections ☐ Magellan Behavioral Health ☐ United Healthcare/Optum ☐ Other (Please select all that apply.)
Please specify.	__________________________________
Is your agency a Child Advocacy Center?	◯ Yes ◯ No

SAMPLE

Please specify what type of entity.	__________________________________
Do you currently see Louisiana Medicaid clients?	◯ Yes ◯ No
Do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.	__________________________________
Do you see patients in a clinical setting?	◯ Yes ◯ No
Please list all insurance plans you accept for payment, including Medicare and private health policies.	__________________________________
Are you actively treating children and adolescents? 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.	◯ Yes ◯ No
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
Which of the following best describes the applicant?	◯ Female ◯ Male ◯ Other
Please specify:	__________________________________
Does the applicant consider themselves to be Hispanic, Latino, or of Spanish origin?	◯ Yes ◯ No
Which of the following best describes the applicant race?	◯ American Indian or Alaska Native ◯ Asian ◯ Black or African American ◯ Native Hawaiian or Pacific Islander ◯ White or Caucasian ◯ Multiple races ◯ Other
Please specify the applicant race:	__________________________________
Please select the STATE applicant is licensed to practice in	◯ LA ◯ Other
Please specify which state utilizing 2 letter state abbreviations:	__________________________________

SAMPLE

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
What is the highest degree completed to date?	◯ Bachelor's ◯ Master's ◯ Doctorate/PhD ◯ In Progress
Please specify the degree type obtained	__________________________________
Please specify month and year of completion:	__________________________________ (Please provide month and year)
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
Indicate MONTH and YEAR of licensure or expected licensure	__________________________________
Please select your Provisional License/ License Type.	◯ CSW ◯ LMSW ◯ LCSW ◯ LCSW-BACS
Have you been licensed or will you be receiving licensure?	◯ Yes ◯ No

SAMPLE

Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
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 ☐ LMSW ☐ LCSW ☐ LCSW-BACS ☐ PhD ☐ PsyD ☐ Other
Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
Indicate MONTH and YEAR of licensure or expected licensure	________________________________ (Please indicate month and year)
Please specify:	________________________________
Please enter your LICENSE NUMBER(s) with your respective credential:	____
Please enter your LICENSE NUMBER(s) with your respective credential:	____
Please enter your LICENSE NUMBER(s) with your respective credential:	____

SAMPLE

Please enter your LICENSE NUMBER(s) with your respective credential:	______________________________
Please enter your LICENSE NUMBER(s) with your respective credential:	______________________________
What is your NPI number?	________________________
Are you proficient in any other languages other than English?	◯ Yes ◯ No
Please elaborate.	________________________

SAMPLE

SECTION 3 OF 6- AGENCY INFORMATION

Name of Applicant Agency ________________

Agency Street Address ________________

Agency City ________________

Agency State
◯ LA
◯ Other

Other (please specify state using 2 lettered abbreviations): ________________

Agency Zip Code ________________

Agency Mailing Address (if different from Agency Street Address) ________________

Agency NPI (if known) ________________

SAMPLE

SECTION 4 OF 6- TRAINEE PCIT APPLICATION QUESTIONS. THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT.

Describe your experience serving young children and their families by filling out the following table. (Example: We currently serve both children individually and in family therapy. We provide transportation, supervision of visits, parenting, behavioral aide, Community Support Individual, Prescription clinic psychiatric and nursing services). Please limit response to 100 words. If not applicable, please denote N/A:

Total number of children served in the past year: ______
Number of children served between ages 2 and 7 in the past year: ______
Treatment modalities you have used: ______

What age range does your agency primarily serve?

- ◯ 2-7 years old
- ◯ 8-18 years old
- ◯ 19-21 years old
- ◯ 22+ years old

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.

____

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

____

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:

____

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.

____

SAMPLE

Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive PCIT? Please limit response to 100 words.	__________________________________
What is your current caseload per week? Can you add/utilize the PCIT practice with your current caseload/clients? Please limit response to 100 words.	__________________________________
Explain how PCIT would fit your agency/practice and the community you serve. Please limit response to 100 words.	__________________________________

SAMPLE

SECTION 5 OF 6- IMPLEMENTATION SUPPORT

How many people in your agency have been trained in PCIT?

____

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

◯ Yes
◯ No

Please provide the first and last name(s) of the leadership that would be interested in attending the 1-hour PCIT Implementation Discussion:

____
(Please input first and last name(s))

Please provide the email address(es) of the leadership that would be interested in attending the 1-hour PCIT Implementation Discussion:

____
(Please input emails)

Would your agency leadership be also interested in auditing the PCIT training to better support clinical staff?

◯ Yes
◯ No

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

◯ Yes
◯ No

Please explain. Please limit response to 100 words.

____

How did you hear about the PCIT 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:

____

SAMPLE

SECTION 6 OF 6- COMMITMENT FROM CLINICIAN
Please ensure to review each of the following requirements to confirm you are able to participate in the PCIT Training.

By selecting, "Yes, I can commit" below, you commit to do the following:

	Yes, I can commit.	No, I cannot commit.
(1) I will attend all training sessions.	○	○
(2) I will attend 80% or more of bi-monthly group consultation calls.	○	○
(3) I will communicate with my agency/supervisor/leadership if changes need to be made in my caseload to acquire the appropriate cases to implement PCIT.	○	○
(4) I will submit four videos of treatment sessions or permit a trainer to join four treatment sessions.	○	○
(5) I will graduate two families from PCIT.	○	○

Date of application completion: ______________________

We highly recommend you reconsider to better prepare you for your PCIT training experience.

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 PCIT training. The agency agreement must be completed by January 18, 2025.

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.)

Please review any of your responses on previous pages before submitting your application.

To receive a PDF copy of your application responses, please type in your E-MAIL ADDRESS in the on the next page.

SAMPLE