2025 Preschool and Youth PTSD Treatment (PPT/YPT) Application for Cohort 5

Please complete the application below.

SECTION 1 OF 7: APPLICATION INSTRUCTIONS

Preschool and Youth PTSD Treatment (PPT/YPT) Individual Application - Spring 2025

The PPT/YPT online training is scheduled for Spring 2025. The course instructor is Devi Miron Murphy, PhD for this training opportunity.
The training application requires TWO (2) FORMS to be completed for EVERY APPLICANT, the Trainee Application, AND the Agency Agreement.

Please review the PPT/YPT Request for Applications (RFA) in its entirety for complete details about the training before completing an application"

You can click here to access the PPT/YPT RFA.

Application Instructions: 1. The TRAINEE APPLICATION must be completed by each applicant and can be accessed by filling out the online application (through REDCap) by February 28, 2025.
2. 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 PPT/YPT training. Even if an applicant is a sole practitioner, they must submit an agency agreement on behalf of themselves. The agency agreement MUST BE EMAILED TO EvidenceToPractice@lsuhsc.edu by February 28, 2025.

Click to access the AGENCY AGREEMENT.

BOTH FORMS MUST BE SUBMITTED 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 7 - 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 _____

Applicant Phone Number _____

Applicant E-mail address	_____
What type of agency do you 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
What is your NPI number?	_____
If other, please indicate which type	_____ (Please type in the type of agency worked at)
Please specify the agency type:	◯ Sole practice provider ◯ Agency-based provider ◯ Both (sole practice provider AND agency-based provider)
What is applicant's employment status with this agency?	◯ Full-time ◯ Part-time ◯ Contract ◯ Temporary ◯ Other
Please describe	_____
Are you a Louisiana Medicaid provider?	◯ Yes ◯ No
By selecting "Yes," which MCO plans (select all that apply)?	☐ Aetna Better Health ☐ Amerihealth Caritas of Louisiana ☐ Healthy Blue/ Anthem ☐ Humana Healthy Horizons ☐ Louisiana Healthcare Connections ☐ Magellan Behavioral Health ☐ United Healthcare/ Optum
By selecting "No," is your agency a Child Advocacy Center? If not, please specify what type of entity.	_____
Do you currently see Louisiana Medicaid clients?	◯ Yes ◯ No
Do you currently see Medicaid clients in a direct clinical mental health practice?	◯ Yes ◯ No

Do you currently see those Medicaid clients for a minimum of 45-60-minute psychotherapy sessions? Please describe.	_____
Please list all insurance plans you accept for payment, including Medicare and private health policies:	_____
Are you actively treating children and families? 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
If you selected YES, please describe. Please describe if this applicant works with the child or adult, family-level treatment, etc. Please limit response to 150-200 words.	_____
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
If selected 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?	◯ American Indian or Alaksa 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 that the participant is licensed to practice in	◯ LA ◯ Other
Please specify which state utilizing 2 letter state abbreviations	_____ (Please utilize 2-lettered state abbreviations)

Which of the following region(s) does the applicant provides services to? Please select all that apply.	☐ Region 1: 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
Educational Degree(s)	_____ (Please indicate month and year)
Please specify month and year of anticipated graduation date	_____
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 indicate month and year)
Please select your Provisional License/ License Type.	◯ CSW ◯ LMSW ◯ LCSW ◯ LCSW-BACS
Indicate MONTH and YEAR of licensure or expected licensure	_____ (Please indicate month and year)

Please select your Provisional License/ License Type.	◯ PhD ◯ PsyD
Indicate MONTH and YEAR of licensure or expected licensure	_____ (Please indicate month and year)
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)
I hold the following credential	_____
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	_____
Please enter your LICENSE NUMBER(s) with your respective credential	_____
Please enter your LICENSE NUMBER(s) with your respective credential	_____
Are you proficient in any other languages other than English?	◯ Yes ◯ No
Please elaborate.	_____

SECTION 3 OF 7- AGENCY INFORMATION

This questionnaire is to be completed by each applicant.

Name of Applicant Agency	_____
Agency Street Address	_____
Agency City	_____
Agency State	◯ LA ◯ Other
Other (please specify state using 2 lettered abbreviations)	_____ (Input 2-lettered state abbreviation)
Agency Zip Code	_____
Agency Mailing Address (if different from agency street address)	_____
Agency NPI (if known)	_____

SECTION 4 OF 7- TRAINING DATES.
THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT.

The Center for Evidence to Practice will be sponsoring one (1) cohort of Preschool and Youth PTSD Treatment (PPT/YPT) training in Spring 2024. Applicants must be able to commit to and participate in ALL training components: an 8-hour training day and weekly 1-hour consultation calls for up to 3-6 months. This is a requirement to participate in this training opportunity.

	Yes, I can attend/participate	No, I cannot attend/participate
8-HOUR TRAINING DAY: March 21, 2025 (8:30am- 4:30pm CDT)	○	○
CONSULTATION CALLS: Attend weekly 1-hour consultation calls with Dr. Devi Murphy following the March 21st Training for up to 3-6 months	○	○

SECTION 5 OF 7- PPT/YPT APPLICATION TRAINEE QUESTIONS.

This application is to be completed by each applicant.

Have you received training or education focused on early childhood development?	◯ Yes ◯ No
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 150-200 words.	_____
Please list any EBP you completed training in, where you were first trained and your certification status. Please be as specific as possible.	_____
Please explain what training or education you received related to early childhood development?	_____
Given the population you provide services to, what are their age ranges? Please select all that apply.	☐ 0-3 years old ☑ 3-6 years old ☐ 7-18 years old
How many years of clinical experience do you have working with children?	_____
Are you currently enrolled in another EBP training?	◯ Yes ◯ No
When will you complete this training? Please be as specific as possible about which EBP training and the remaining training timeline.	_____
Have you had experience with or training in Cognitive Behavioral Therapy (CBT)? Please limit response to 250-300 words.	_____
Describe the geographic area and population served at your agency. Additionally, please mention any unique characteristics of this population. Please limit response to 150-200 words.	_____
Describe your agency's current sources for child/caregiver referrals. Do you anticipate any challenges in finding families who would be able to receive PPT/YPT? Please limit response to 150-200 words.	_____

What is your current caseload per week? Can you add/utilize the PPT/YPT practice with your current caseload/clients? Please limit response to 150-200 words.

_____

Explain how PPT/YPT would fit your agency/practice and the community you serve. Please limit response to 150-200 words.

_____

SECTION 6 OF 7- IMPLEMENTATION SUPPORT

How many people in your agency/practice have been trained in PPT/YPT? If known, please share.

_____
(Please enter an integer)

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 Likely
◯ Likely
◯ Neutral
◯ Unlikely
◯ Very Unlikely

If chosen for this training opportunity, what is your level of availability to participate in a learning community for 1-1.5 hours per month?

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

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

◯ Yes
◯ No

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

◯ Yes
◯ No

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

◯ Yes
◯ No

If so, please list them

_____

How did you hear about the PPT/YPT training opportunity through the Center for Evidence to Practice? Select all that apply if applicable.

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

Please specify

_____

SECTION 7 OF 7- APPLICATION CHECKLIST

Please review PRIOR to submitting your application.

	Yes	No _____
Please review the Request for Application (RFA) to be aware of training expectations. You can access the PPT/YPT RFA by clicking this link: _____	◯	◯
(HIGHLY RECOMMENDED) ATTEND OR WATCH RECORDING OF THE INFORMATIONAL WEBINAR so applicants are aware of the training expectations and time commitment. Accessible by clicking this link: _____	◯	◯
SAVE ALL IMPORTANT TRAINING DATES: Please review Pg. 8 for all important dates in our PPT/YPT RFA: _____	◯	◯
Submit a TRAINEE APPLICATION, acceptance into the training will be evaluated on an individual basis based on the application responses.	◯	◯
Submit an AGENCY AGREEMENT on behalf of your agency. This step is necessary for those that are sole practitioners as well, please fill it out on behalf of yourself. You can access the Agency Agreement by clicking this link: _____	◯	◯

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 FEBRUARY 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.)

APPLICATION DEADLINE: FEBURARY 18, 2025

Applicants will be notified via email by FEBRUARY 28, 2025 regarding their status in the online training. Acceptance is based on meeting the eligibility requirements explained in the PPT/YPT RFA.

Since there is limited availability of spaces for the training sponsored by the Center for Evidence to Practice; applicants who are not accepted can sign up for our MailChimp mailing listserv to stay informed of future training opportunities.

Applicants can sign up for our mailing listserv by clicking this link: https://lsuhsc.us20.list-manage.com/subscribe?u=b2045d7fb10485464b8e645c5&id=69bc0df273

Thank you for your commitment to serving Louisiana's children and families.

We look forward to reading your application!

The Center for E2P Team

Feel free to email Evidence to Practice if you have any questions!

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.