Triple P Application for Cohort 2

Please complete the Triple P Application below.

SECTION 1 OF 7- APPLICATION INSTRUCTIONS

The Triple P (Level 4) online training is scheduled to begin in Spring 2025. The course instructors are Triple P America 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 PPP Request for Applications (RFA) in its entirety for complete details about the training prior to completing an application.

You can click here to access the Triple P RFA:
https://laevidencetopractice.com/wp-content/uploads/2025/03/Triple-P-Online-Training_RFA_DRAFT_03.25.25_1.pdf

The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the PPP 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 CPP APPLICATION. The deadline for completion is APRIL 25 2025.

BOTH FORMS MUST BE COMPLETED FOR EACH PPP 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 7 - PPP 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 PPP TRAINING IS ACCEPTING MEDICAID AND ACTIVELY TREATING CHILDREN AND ADOLESCENTS)

Applicant First Name: _____

Applicant Last Name: _____

Applicant Job Title: _____

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
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:	_____

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 enter your LICENSE NUMBER(s) with your respective credential	_____
Please select your Provisional License/ License Type.	◯ CSW ◯ LMSW ◯ LCSW ◯ LCSW-BACS

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

SECTION 3 OF 7- 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)	_____

SECTION 4 OF 7- TRAINEE Triple P 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 0 and 5 in the past year: _____
Treatment modalities you have used: _____

Have you received training or education focused on early childhood development?
◯ Yes
◯ No

Please explain what training or education you received related to early childhood development?
_____

Have you previously received training in Positive Parenting Program (Triple P)?

It doesn't have to be exclusive to Level 4, it could be regarding the other levels of the model.
◯ Yes
◯ No

Please explain WHEN that training took place and for what level regarding the Positive Parenting Program - Triple P?
_____

What age range does your agency primarily serve?
◯ 0-5 years old
◯ 6-12 years old

How many years of clinical experience do you have working with children?
_____

Please specify the age range of children served.

Would you have a supervisor that supports you as a practitioner?

Note: The supervisor is welcome to audit the training if they are available and interested.
◯ Yes
◯ No

Would the supervisor be willing to join a supervisory group?
◯ Yes
◯ No

Please explain:

Please limit response to 100 words
_____

What are your perspectives on self-regulation and viewing a parent as a partner in the work of achieving Triple P goals?

Please reference the Triple P RFA to familiarize yourself with the Triple P goals (pg. 5): https://laevidencetopractice.com/wp-content/uploads/2025/03/Triple-P-Online-Training_RFA_DRAFT_03.25.25_1.pdf

_____

Describe your agency's current sources for child/caregiver referrals. Do you anticipate any challenges in finding children and their caregivers that have a history of trauma? Please limit response to 100 words.

_____

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:

_____

How do you incorporate families and caregivers into the therapy sessions with children?

Please limit response to 100 words.

_____

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.

Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive Triple P?
Please limit response to 100 words.

What is your current caseload per week? Can you add/utilize the Triple P practice with your current caseload/clients?
Please limit response to 100 words.

Explain how Triple P would fit your agency/practice and the community you serve.
Please limit response to 100 words.

SECTION 5 OF 7- IMPLEMENTATION SUPPORT

How many people in your agency have been trained in Triple P?

_____

If chosen for this opportunity, would your agency leadership be interested in attending a 1-hour Triple P implementation discussion BEFORE beginning PPP training with clinicians (May 14, 2025 12pm- 1:15pm)?

◯ Yes
◯ No

Please provide the FIRST AND LAST NAME(S) of the leadership that would be interested in attending the 1-hour Triple P 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 PPP Implementation Discussion:

_____
(Please input emails)

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

◯ Yes
◯ No

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

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 Unlikely
◯ Unlikely
◯ Neutral
◯ Likely
◯ Very Likely

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 Triple P 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 6 OF 7: Can the applicant participate in the following training dates?

The Center for Evidence to Practice will be sponsoring one (1) cohort of Triple P (PPP) training in Spring 2025- Spring 2026. Applicants must be able to commit to and participate in ALL training dates listed below. This is a requirement in order to participate in this training opportunity.

	Yes, I can attend/participate	No, I cannot attend/participate
Triple P MANDATORY Orientation Meeting & Agency Leadership Touch Base: Wednesday, May 14, 2025 from 12pm-1:15pm CST _____	○	○
Triple P Standard Training: June 11-13, 2025 from 9:00am-4:30pm	○	○
Triple P Pre-Accreditation: Wednesday July 16, 2025 from 9:00am-4:30pm CST	○	○
Triple P Accreditation: July 29-30, 2025 from 9:00am-5:00pm . *Each practitioner will be assigned a half-day time block to execute accreditation between these two (2) days.	○	○
Consultation Call Commitment: Attend monthly 1-hour consultation calls for six (6) months: July 2025-December 2025	○	○

SECTION 7 OF 7- COMMITMENT FROM CLINICIAN

Please ensure to review each of the following requirements to confirm you are able to participate in the PPP 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 dates/times: _____	○	○
(2) I will attend monthly consultation calls for 6 months from July 2025- December 2025	○	○
(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 Triple P	○	○
(4) I will review the REQUEST FOR APPLICATION (RFA) to be aware of training expectations. You can access the PPP RFA by clicking this link: _____	○	○
(5) I will watch recordings of the informational webinar so I am aware of the training expectations and time commitment. Accessible on our E2P Learn Platform: _____	○	○
(6) I will submit a TRAINEE APPLICATION	○	○
(7) I will submit an AGENCY AGREEMENT on behalf of my agency. You can access the Agency Agreement by clicking this link: _____	○	○

We highly recommend you reconsider to better prepare you for your PPP 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 PPP training. The agency agreement must be completed by APRIL 25, 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.