Parent Child Interaction Therapy (PCIT) Application (Cohort 5)

Please complete the application below.

PCIT INDIVIDUAL APPLICATION

The PCIT online training is scheduled to begin in Spring 2026 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.

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

RFA.

SECTION 1 OF 8- APPLICATION INSTRUCTIONS

(1) 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 October 26, 2025.

(2) 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 October 26, 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 8 - 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 Email Address:	_____ (Please verify that your email address is typed correctly.)
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 ◯ Licensed Mental Health Professional (LMHP) Group Practice ◯ Other
Please specify the agency type:	◯ Sole practice provider ◯ Agency-based provider ◯ Both (sole practice provider AND agency-based provider)
If other, please indicate which type	_____ (Please indicate the type of agency you work at)
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
By selecting "Yes," which MCO plans are you contracted with (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 (Please select all that apply.)
By selecting "No," you indicated you are not a Medicaid Provider, is your agency a Child Advocacy Center or a School- Based Health System?	◯ Yes ◯ No
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 minutes 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 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 and the survey will end.	◯ Yes ◯ No
By selecting 'YES', 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 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's race	_____
Please select the STATE applicant 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? 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
What is the highest degree completed to date?	◯ Bachelor's ◯ Master's ◯ Doctorate/PhD ◯ In Progress
Educational Degree(s)	_____
Please specify month and year of anticipated graduation date	_____ (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 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.	◯ Provisional Licensed Psychologist (PLP) ◯ Licensed Psychologist (LP) ◯ Licensed Specialist in School Psychology (LSSP)
Indicate MONTH and YEAR of licensure or expected licensure	_____ (Please indicate month and year)
I hold the following credential	_____
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 ☐ PLP ☐ LP ☐ LSSP ☐ 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)
Please specify:	_____
Indicate MONTH and YEAR of licensure or expected licensure	_____ (Please indicate month and year)
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:	_____
What is your NPI number?	_____
Are you proficient in any other languages other than English?	◯ Yes ◯ No
Please elaborate.	_____

SECTION 3 OF 8- 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):	_____
Agency Zip Code	_____
Agency Mailing Address (if different from Agency Street Address)	_____
Agency NPI (if known)	_____

SECTION 4 OF 8- TRAINING DATES

Can the applicant attend the following training dates?

****Does this need to be revised??** The Center for Evidence to Practice will be sponsoring one (1) cohort of Parent Child Interaction Therapy (PCIT) training in Spring 2026. Applicants must be able to commit to and participate in ALL training components: 5x 8-hour training days and attend 1-hour bi-weekly consultation calls for one (1) year. This is a requirement to participate in this training opportunity.**

	Yes, I can attend/participate	No, I cannot attend/participate _____
E2P Training Commitment due on Friday, November 14, 2025	◯	◯
PCIT Textbook request form is due on Friday, November 14, 2025	◯	◯
PCIT Agency Leadership Meeting 1 on Wednesday, November 19, 2025 from 12:00pm- 1:00opm CST	◯	◯
PCIT Orientation Meeting on Wednesday December 10, 2025, from 12:00pm to 1pm CST	◯	◯
PCIT 5-Day Training from January 7-9; 12-13, 2026 from 9:00AM-5;00PM	◯	◯
CE Evaluation due on January 21, 2026	◯	◯
FIRST Consultation Call will occur on week of January 26-30, 2026	◯	◯
Consultation Call Commitment: attend 1 hour bi-weekly consultation calls for one year	◯	◯
PCIT Leadership Meeting #2: March XXXXXX. 2026 from at specific times. ** Just Leadership Attendance (meet 1:1 with agencies)	◯	◯
PCIT 2-day Training: April 30-May 1, 2026 from 9:00AM-5:00PM CDT	◯	◯
CE Evaluation Deadline: Friday May 8, 2026	◯	◯

PCIT Leadership Meeting #3: June DATE XXXXX, 2026 from at specific times Just Leadership Attendance (group-wide meeting?)	○	○

****DOUBLE CHECK QUESTIONS****

SECTION 5 OF 8- 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: _____

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.
☐ 2-7 years old
☐ 8-18 years old
☐ 19-21 years old
☐ 22+ 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, including month and year of anticipated completion.

Describe the geographic area and population served at your agency. Be sure to mention any unique characteristics of this population.
Please limit response to 150-200 words.

_____

Describe your agency's current source of referrals. Do you anticipate any challenges in finding clients who would be able to receive PCIT?
Please limit response to 150-200 words.

_____

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

_____

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

_____

SECTION 6 OF 8- IMPLEMENTATION SUPPORT

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

(Please input emails)

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 PCIT training opportunity through the Center for Evidence to Practice? Select all that apply.

- ☐ Evidence to Practice (E2P) MailChimp Listserv and/or E2P Direct Email
- ☐ Director, Supervisor, or Manager
- ☐ Word of Mouth
- ☑ Social Media Advertisement
- ☐ Direct Email Outreach (not from E2P)
- ☐ Other

(Select all that apply.)

Please specify how you heard about this training opportunity:

_____

****NEED TO REVISE****

SECTION 7 OF 8- 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 PCIT 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 PCIT 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: {aalink}	○	○

We highly recommend you revisit and COMPLETE this step.

SECTION 8 OF 8- TRAINEE CHECKLIST

By applying for the PCIT Training Protocol, I understand that if accepted, I will be expected to complete the following (please review prior to submitting your application)

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

	Yes, I can commit.	No, I cannot commit. _____
(1) I attest that I meet ALL of the prerequisites to participate in the PCIT training protocol.	○	○
(2) I agree to complete the PCIT training protocol in its ENTIRITY.	○	○
(3) I acknowledge my SUPERVISOR has approved my attendance to this training protocol.	○	○
(4) I acknowledge that my Program Head/Clinic Manager knows of my participation in the training AND is agreeing to clear time in my schedule to complete the entire PCIT training program.	○	○
(5) I acknowledge that I currently have access to Zoom with VIDEOCONFRENCING CAPABILITIES for the purposes of participating in all training days.	○	○

PLEASE UPLOAD YOUR SIGNED AND COMPLETED AGENCY AGREEMENT FORM HERE.

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

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

APPLICATION DEADLINE: OCTOBER 26, 2025

Applicants will be notified via email by NOVEMBER 3, 2025 regarding their status in the online training. Acceptance is based on meeting the eligibility requirements explained in the PCIT 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.