

# Preschool and Youth PTSD Treatment (PPT/YPT) Application for Cohort 6

Please complete the application below.

## PPT/ YPT APPLICATION INSTRUCTIONS

The PPT/YPT online training is scheduled for Spring 2026. 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 PPT/YPT 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.

## SECTION 1 OF 8- APPLICATION INSTRUCTIONS

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

This must be completed by NOVEMBER 19, 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 NOVEMBER 19, 2025.

**\*\*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 8 - PPT/YPT 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 PPT/YPT 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

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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
- 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 type in the type of agency worked at)

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What is applicant's employment status with this agency?

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

Please describe

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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," 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.

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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?

- 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 and the survey will end.

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 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 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 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, Jefferson
- 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 indicate 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

\_\_\_\_\_

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 )

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.

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**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)

\_\_\_\_\_ (Input 2-lettered state abbreviation)

Agency Zip Code

\_\_\_\_\_

Agency Mailing Address (if different from agency street address)

\_\_\_\_\_

Agency NPI (if known)

\_\_\_\_\_

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**SECTION 4 OF 8- TRAINING DATES**

**Can the applicant attend the following training dates?**

**The Center for Evidence to Practice will be sponsoring one (1) cohort of Preschool and Youth PTSD Treatment (PPT/YPT) training in Spring 2026. 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: January 22, 2026 (8:30am- 4:30pm CDT)	<input type="radio"/>	<input type="radio"/>
CONSULTATION CALLS: Attend weekly 1-hour consultation calls with Dr. Devi Murphy following the January 22nd Training for up to 3-6 months	<input type="radio"/>	<input type="radio"/>

SAMPLE

**SECTION 5 OF 8- PPT/YPT APPLICATION TRAINEE 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 3 and 6 in the past year: \_\_\_\_\_  
 Number of children served between ages 7 and 18 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.

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.

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.

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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.

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

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**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

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

- Yes
- No

If so, please list them

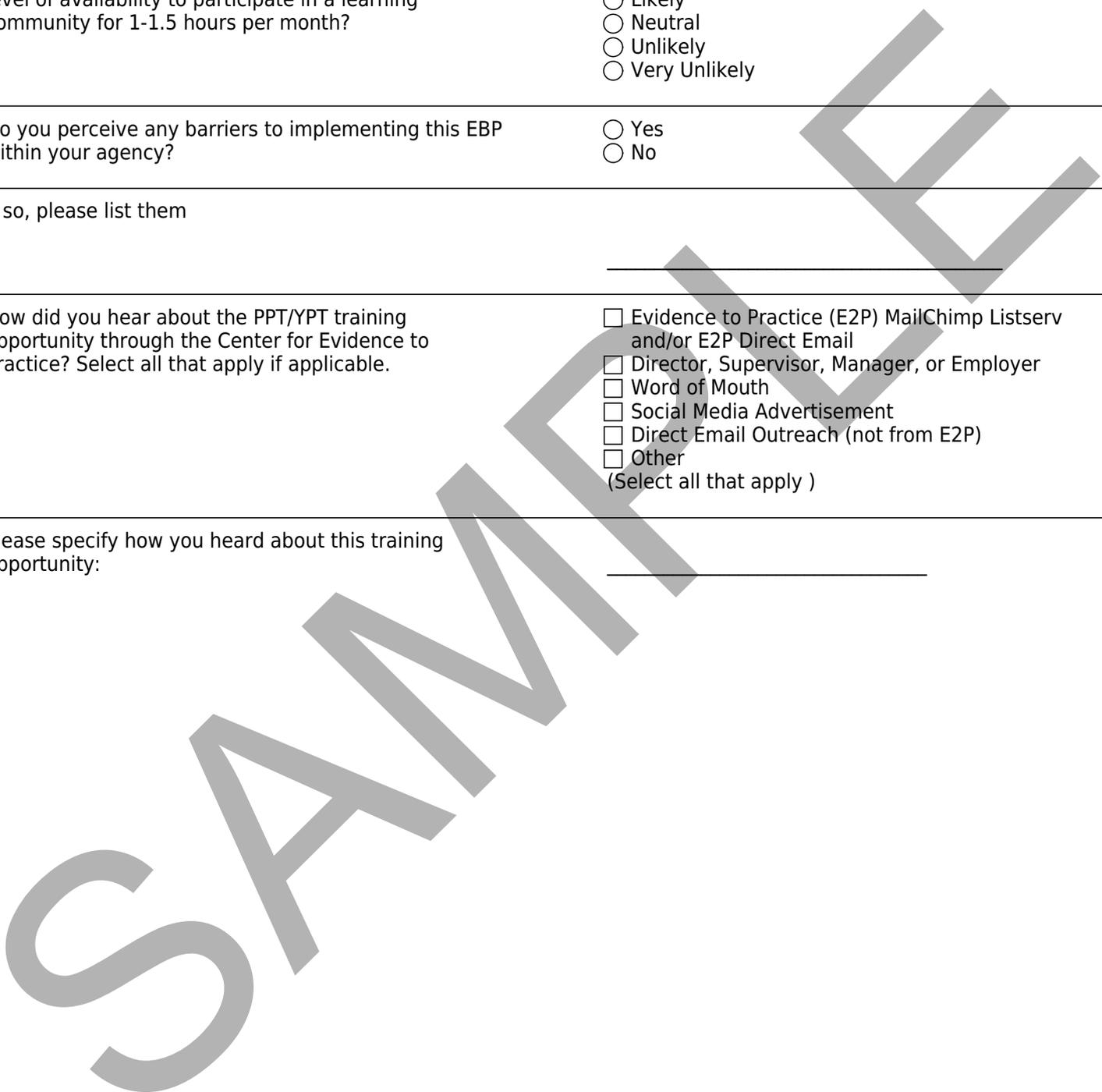
\_\_\_\_\_

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)
  - Other
- (Select all that apply )

Please specify how you heard about this training opportunity:

\_\_\_\_\_



**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 PPT/YPT RFA by clicking this link: _____	<input type="radio"/>	<input type="radio"/>
(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: _____	<input type="radio"/>	<input type="radio"/>
SAVE ALL IMPORTANT TRAINING DATES: Please review Pg. 7 for all important dates in our PPT/YPT RFA: _____	<input type="radio"/>	<input type="radio"/>
Submit a TRAINEE APPLICATION, acceptance into the training will be evaluated on an individual basis based on the application responses.	<input type="radio"/>	<input type="radio"/>
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: _____	<input type="radio"/>	<input type="radio"/>

SAMPLE

**SECTION 8 OF 8- TRAINEE CHECKLIST**

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

	Yes	No <u>    </u>
(1) I attest that I meet ALL of the prerequisites to participate in the PPT/YPT training protocol.	<input type="radio"/>	<input type="radio"/>
(2) I agree to complete the PPT/YPT training protocol in its ENTIRETY.	<input type="radio"/>	<input type="radio"/>
(3) I acknowledge my SUPERVISOR has approved my attendance to this training protocol.	<input type="radio"/>	<input type="radio"/>
(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 PPT/YPT training program.	<input type="radio"/>	<input type="radio"/>
(5) I acknowledge that I currently have access to Zoom with VIDEOCONFERENCING CAPABILITIES for the purposes of participating in all training days.	<input type="radio"/>	<input type="radio"/>

**\*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: NOVEMBER 19, 2025**

Applicants will be notified via email by December 3, 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!

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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.

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