# Trauma Grief and Component Therapy for Adolescents (TGCA) Cohort 1 Application

Hello,

We thank you for your interest in the TGCA training opportunity. The application will open on TUESDAY FEBRUARY 3, 2026. Please check on or after that date to apply. The application will be open until MARCH 20, 2026. You will be notified of your status by APRIL 1, 2026. We look forward to receiving your application during the application period. Please reach out to the Center (EvidencetoPractice@lsuhsc.edu) if you have any questions.

Warm Regards,

Center Staff

Center for Evidence to Practice

LSUHSC -NO, School of Public Health

for EBP Trainings: (504) 568-5731

laevidencetopractice.com

Sign-up for our newsletter!



## SECTION 1 OF 7: APPLICATION INSTRUCTIONS

**Trauma Grief and Component Therapy for Adolescents (TGCA) Individual Application - Spring 2026**

**The TGCA online training is scheduled for Spring 2026. The course instructors are XXXXXXXXXXX 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 TGCA 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 RFA

Application Instructions: 1. The INDIVIDUAL APPLICATION must be completed by each applicant and can be accessed by filling out the online application (through REDCap) by MARCH 20, 2026.
2. The AGENCY AGREEMENT must be filled and signed through Adobe Acrobat (or a similar PDF editing software) by a supervisor and/or administrator at the agency requesting participation in the TGCT training. Even if an applicant is a sole practitioner, they must submit an agency agreement on behalf of themselves. The agency agreement MUST BE SUBMITTED via the Individual Application by MARCH 20, 2026.

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 - TGCA 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 TGCA TRAINING IS ACCEPTING MEDICAID AND ACTIVELY TREATING 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<br>◯ Human Services District/Authority<br>◯ Medical Center (either inpatient or outpatient)<br>◯ Behavioral Health Service Provider (BHSP), providing Mental Health Rehabilitation services<br>◯ Independent Mental Health Practitioner/ Private Practice<br>◯ LMHP Group Practice<br>◯ Other |
| Please list any other applicable agency types | _____ |
| If other, please indicate which type | _____<br>(Please type in the type of agency worked at) |
| Please specify the agency type: | ◯ Sole practice provider<br>◯ Agency-based provider<br>◯ Both (sole practice provider AND agency-based provider) |
| What is applicant's employment status with this agency? | ◯ Full-time<br>◯ Part-time<br>◯ Contract<br>◯ Temporary<br>◯ Other |
| Please describe | _____ |
| Are you a Louisiana Medicaid provider? | ◯ Yes<br>◯ 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 adolescents 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

- ◯ Yes
- ◯ No

If you selected YES, please describe.
Please describe if this applicant works with the adolescent 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 Alaska Native<br>◯ Asian<br>◯ Black or African American<br>◯ Native Hawaiian or Pacific Islander<br>◯ White or Caucasian<br>◯ Multiple races<br>◯ Other |
| Please specify the applicant race | _____ |
| Please select the STATE that the participant is licensed to practice in | ◯ LA<br>◯ Other |
| Please specify which state utilizing 2 letter state abbreviations | _____<br>(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<br>☐ Region 2: Ascension, East Baton Rouge, East Feliciana, Iberville, Point Coupee, West Baton Rouge, West Feliciana<br>☐ Region 3: Assumption, Lafourche, St Charles, St. James, St. John, St. Mary, Terrebonne<br>☐ Region 4: Acadia, Evangeline, Iberia, Lafayette, St. Landry, St. Martin, Vermillion<br>☐ Region 5: Allen, Beauregard, Calcasieu, Cameron, Jefferson Davis<br>☐ Region 6: Avoyelles, Catahoula, Concordia, Grant, LaSalle, Rapides, Vernon, Winn<br>☐ Region 7: Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine, Webster<br>☐ Region 8: Caldwell, East Carroll, Franklin, Jackson, Lincoln, Madison, Morehouse, Ouachita, Richland, Tensas, Union, West Carroll<br>☐ Region 9: Livingston, St. Helena, St. Tammany, Tangipahoa, Washington |
| What is the highest degree completed to date? | ◯ Bachelor's<br>◯ Master's<br>◯ Doctorate/PhD<br>◯ In Progress |
| Educational Degree(s) | _____<br>(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<br>◯ Social Worker<br>◯ Psychologist<br>◯ More than one credential type<br>◯ I have another type of credential<br>◯ I do not hold a credential |

| | |
|---|---|
| Please select your Provisional License/ License Type. | ◯ PLPC<br>◯ LPC<br>◯ LPC-S<br>◯ PLMFT<br>◯ LMFT |
| Indicate MONTH and YEAR of licensure or expected licensure | _____<br>(Please indicate month and year ) |
| Please select your Provisional License/ License Type. | ◯ CSW<br>◯ LMSW<br>◯ LCSW<br>◯ LCSW-BACS |
| Indicate MONTH and YEAR of licensure or expected licensure | _____<br>(Please indicate month and year ) |
| Please select your Provisional License/ License Type. | ◯ PhD<br>◯ PsyD |
| I hold the following credentials (please select all that apply) | ☐ PLPC<br>☐ LPC<br>☐ LPC-S<br>☐ PLMFT<br>☐ LMFT<br>☐ CSW<br>☐ LMSW<br>☐ LCSW<br>☐ LCSW-BACS<br>☐ PhD<br>☐ PsyD<br>☐ Other |
| Indicate MONTH and YEAR of licensure or expected licensure | _____<br>(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

_____

What is your NPI number?

_____

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**

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

| | Yes, I can attend/participate | No, I cannot attend/participate |
|---|---|---|
| MANDATORY Pre-Requisite TGCA Assessment Training: April 21, 2026 from 12:00PM-1:00PM CT | ◯ | ◯ |

| | | |
|---|---|---|
| TGC Adolescents Learning Collaborative - May 13-14, 2026, from 9:00am-4:30pm CT | ◯ | ◯ |
| Consultation Calls: Attend monthly consultation calls for the next six (6) months - with opportunity for more | ◯ | ◯ |

We ask that you reconsider for a more successful TGCT application.

## SECTION 5 OF 7- TGCA APPLICATION TRAINEE QUESTIONS

**This application is to be completed by each applicant.**

Do you already serve adolescents in foster care?
◯ Yes
◯ No

If yes, please explain:
_____

Do you already serve Department of Children and Family Services (DCFS) involved youth?
◯ Yes
◯ No

If yes, please explain:
_____

Do you have training or education in trauma?
◯ Yes
◯ No

Do you have training or education in bereavement?
◯ Yes
◯ No

Do you see adolescents who have experienced trauma or loss?
◯ Yes
◯ No

Given the population you provide services to, what are their age ranges? Please select all that apply.
☐ 0-11 years old
☐ 12-18 years old

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

Describe your experience serving Medicaid 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.

Are you currently training in another EBP model?
- ◯ Yes
- ◯ No

When will you complete training for this model?

Please be as specific as possible, including MONTH and YEAR of anticipated completion.

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 adolescent/caregiver referrals. Do you anticipate any challenges in finding families who would be able to receive TGCA?

Please limit response to 150-200 words.

What is your current caseload per week? Can you add/utilize the TGCA practice with your current caseload/clients?

Please limit response to 150-200 words.

Explain how TGCA would fit your agency/practice and the community you serve.

Please limit response to 150-200 words.

How do you plan to use this intervention?
- ◯ Individual Therapy
- ◯ Group Therapy
- ◯ Both- Individual and Group Therapy
- ◯ Not sure yet

## SECTION 6 OF 7- IMPLEMENTATION SUPPORT

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

(Please enter an integer)

If chosen for this opportunity, would your agency leadership be interested in attending a 1-hour TGCA implementation discussion BEFORE beginning TGCA training with clinicians?
- ◯ Yes
- ◯ No

If yes, please list their names and forms of contact:

_____

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

◯ Yes
◯ No

If yes, please list their names and forms of contact:

_____

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 TGCA 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

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 TGCA RFA by clicking this link: _____ | ◯ | ◯ |
| (HIGHLY RECOMMENDED) WATCH the TGCA Recording on our website so applicants are aware of the training expectations and time commitment. Accessible here, once you have selected "YES:" _____ | ◯ | ◯ |
| SAVE ALL IMPORTANT TRAINING DATES: Please review Pg. XX for all important dates in our TGCA 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: _____ | ○ | ○ |

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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 TGCA training. The agency agreement must be completed by MARCH 20, 2026.

You can click on this link to access the AGENCY AGREEMENT

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*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

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APPLICATION DEADLINE: MARCH 20, 2026

Applicants will be notified via email by APRIL 1, 2026 Acceptance is based on meeting the eligibility requirements explained in the TGCA 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 adolescents 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 on the next page.