DBT Application (Cohort 4)

Please complete the application below.

DBT INDIVIDUAL APPLICATION

The DBT online training is scheduled to begin in Fall 2026 with the Treatment Implementation Collaborative for this training opportunity. The course is limited to 4 agencies/teams.

The training application requires the following to be completed for EVERY APPLICANT: DBT application AND the Agency Agreement.

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

DBT RFA.

SECTION 1 OF 9- APPLICATION INSTRUCTIONS

(1) The DBT APPLICATION is to be completed by each applicant and can be accessed by filling out this online application. **Please note, each DBT Application must upload an Agency Agreement. The SAME AGENCY AGREEMENT must be uploaded for all DBT Team members.

This must be completed bySeptember 1, 2026.

(2) TheAGENCY AGREEMENTis to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the DBT 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 DBT APPLICATION. There is a separate portion for agency leadership to complete. TheSAME AGENCY AGREEMENT must be uploaded forthe DBT Team Leadership & DBT Applications.

The AGENCY AGREEMENT must be completed bySeptember 1, 2026.

You can click here to access the DBTRFA:
https://laevidencetopractice.com/wp-content/uploads/2026/07/DBT-Training_RFA_7.26.pdf

**Each DBT Team Member must complete AND have signed the DBT APPLICATION and upload the AGENCY AGREEMENT with their application.

DBT Leadership filling out the AGENCY AGREEMENT must upload the AGENCY AGREEMENT in the DBT APPLICATION.

THIS MUST BE COMPLETED FOR EACH DBT TEAM TO BE CONSIDERED FOR THIS TRAINING OPPORTUNITY**

BOTH FORMS MUST BE COMPLETED FOR EACH DBT 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 9- APPLICATION PRE-REQUISITE

(1) Did leadership within your agency/team attend the DBT Leadership Meeting held on August 14, 2026, from 9:00am- 12:00pm CT.
Leadership at your agency could include but not be limited to: DBT Team Leader, Clinical Directors, Supervisors, Executive Clinical Leadership, etc.

◯ Yes
◯ No

(2) Who was in attendance during that call for your team?

Please enter their first and last name.

_____

(3) Since you did not attend that meeting, please ensure you have done the following:

◯ Yes
◯ No

a. I have contactedHelen Best from the Treatment Implementation Collaborative (TIC) to see if this training is a good fit for me and my DBT team via: Phone: (206) 251-5134; Email: hbest@ticllc.org.

b. If selecting (NO), the application will end as we require you to connect toHelen Best.

(3)b. She has given me the following two words for approval to continue my application:

_____
(Please write the 2 approval words)

SECTION 3 OF 9- DBT 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 DBT 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
☐ Other
(Please select all that apply.)

Please specify.

_____

Is your agency a Child Advocacy Center?

◯ Yes
◯ No

Please specify what type of entity.

_____

Please list all insurance plans you accept for payment, including Medicare and private health policies.

_____

Do you currently see Louisiana Medicaid clients?

◯ 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.

Do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.

_____

Do you see clients in a clinical setting?

◯ Yes
◯ No

Please specify:

_____

Are you actively treating children and families?

◯ Yes
◯ No

By selecting 'No', can you please specify which population you do treat:

_____

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

Of the regions you selected from above, please select the top two (2) regions you serve the most (select NO MORE than 2):

- ☐ Region 1
- ☐ Region 2
- ☐ Region 3
- ☐ Region 4
- ☐ Region 5
- ☐ Region 6
- ☐ Region 7
- ☐ Region 8
- ☐ Region 9

What is the highest degree completed to date?

- ◯ Bachelor's
- ◯ Master's
- ◯ Doctorate
- ◯ 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 select your Provisional License/ License Type.

- ◯ CSW
- ◯ LMSW
- ◯ LCSW
- ◯ LCSW-BACS

Indicate MONTH and YEAR of licensure or expected licensure

_____

Please select your Provisional License/ License Type.

- ◯ Provisional Licensed Psychologist (PLP)
- ◯ Licensed Psychologist (LP)
- ◯ Licensed Specialist in School Psychology (LSSP)

I hold the following credential:

_____

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 specify:

_____

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 4 OF 9- 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 5 OF 9- TRAINEE DBT APPLICATION QUESTIONS. THIS APPLICATION IS TO BE COMPLETED BY EACH APPLICANT.

Briefly describe the nature of your current position.

_____
(Please limit response from 100-150 words)

Why do you want to participate in this training protocol?

_____
(Please limit response to 100-150 words)

Briefly describe your experience in providing services to consumers with severe dysfunctional behaviors, especially those with chronic patterns of emotion dysregulation, suicidal behaviors, non-suicidal, self-injury, and substance use disorders.

_____
(Please limit response to 100-150 words)

Indicate which role(s) you will have in your clinic's DBT program. Please select all that apply.

☐ DBT Team Leader
☐ Skills Group Leader
☐ Skills Group Co-Leader
☐ Individual Therapist

Please elaborate on your selection, regarding your role.

_____
(Please limit your response to 100-150 words)

What is your current caseload? What is your expected DBT caseload?

_____
(Please limit response to 100-150 words)

Describe your background in Behavioral Therapy.

_____
(Please limit response to 100-150 words)

Briefly describe your experience in delivering a comprehensive evidence-based treatment that requires the types of concentrated programming you administer and the collection of outcomes.

_____
(Please limit response to 100-150 words)

Please describe how your agency, leadership intends to support you throughout your training and your delivery of DBT to fidelity. This response should include feedback that your agency leadership (not just a direct supervisor) has provided you regarding their commitments to supporting the implementation of the DBT program at the agency.

Specify what agency you are affiliated with.

_____
(Please limit response to 100-150 words)

Do you feel supported by program/ clinic leadership to implement DBT?

◯ Yes
◯ No _____ _____

What, if any, concerns or barriers do you anticipate experiencing WHILE COMPLETING this training protocol?

_____
(Please limit response to 100-150 words)

What, if any, concerns or barriers do you anticipate experiencing while providing DBT within your agency/clinic AFTER COMPLETING this training protocol?

_____
(Please limit response to 100-150 words)

Are you currently in training for other EBP certifications?

◯ Yes
◯ No

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 (spell out fully EBP followed by abbreviation):

_____

When will you complete this training? Please be as specific as possible, including month and year of anticipated completion.

_____

SECTION 6 OF 9- IMPLEMENTATION SUPPORT

How many people in your agency have been trained in DBT?

_____

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

◯ Yes
◯ No

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

_____
(Please input emails)

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

(Note: "Auditing" entails having your agency leadership attend DBT training just for informative purposes and not to meet training requirements)

◯ Yes
◯ No

**Agency Leadership needs to plan to attend if their agency is accepted for training.

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 DBT 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
☐ Other
(Select all that apply.)

Please specify how you heard about this training opportunity:

_____

SECTION 7 OF 9- Can the applicant participate in the following training dates?

The Center for Evidence to Practice will be sponsoring one (1) cohort of Dialectical Behavioral Therapy (DBT) training in Fall 2026- Spring 2027. 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
Three x 2-hr Team Leader Consultation: The DBT leadership are able to attend Tuesday, September 8, 2026 @ 9am-11am CDT, Tuesday, September 22, 2026 @ 9am-11am CDT, and Tuesday, October 27, 2026 @ 9am-11am CDT.	○	○
5 Half- Day Kick-off: The DBT team are able to attend October 5-9, 2026 @ 9am-1pm CDT	○	○
Online Skills: The DBT team are able to attend September 28, 2026- January 31, 2027	○	○
3- hr program directors (Leadership orientation): The DBT clinic supervisors are able to attend leadership orientation August 14, 2026@ 9:00am-12:00pm CT	○	○
Team Consultation Calls: The DBT team is able to attend 18 bi-weekly consultation sessions for 60 minutes each September 28, 2026 – June 30, 2027	○	○
Session Tapes: The DBT team is able to attend December 4, 2026 - March 31, 2027 (contingency cushion: June 30, 2027)	○	○
3 Half- Day Booster: The DBT team are able to attend February 16-18, 2027 @9am-1pm CT	○	○
Team Case Conceptualizations: The DBT team are able to attend February 18, 2027 - June 30, 2027	○	○

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

Are you in a supervisory role at your agency/ practice?
◯ Yes
◯ No

Are you signing the agency agreement on behalf of the trainees applying at your agency?
◯ Yes
◯ No

Please list the names of the trainees that you are recommending for this training opportunity (provide up to 8 trainee names).

If no other trainee rows are needed, please select N/A or type in N/A in the designated field.

Trainee No.	First Name	Last Name	Role at Agency	License Type	Email Address

Other (please specify) _____

Other (please specify) _____

Other (please specify) _____

Other (please specify) _____

Other (please specify) _____

Other (please specify) _____

Other (please specify) _____

SECTION 8 OF 9- COMMITMENT FROM CLINICIAN

Please ensure to review each of the following requirements to confirm you are able to participate in the DBT 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	○	○
(2) I will attend weekly consultation/supervision calls for 18 months	○	○
(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 DBT	○	○
(4) I will review the REQUEST FOR APPLICATION (RFA) to be aware of training expectations. You can access the DBT RFA by clicking this link: _____	○	○
(5) WATCH RECORDING OF THE DBT INFORMATIONAL WEBINAR RECORDING so applicants are aware of the training expectations and time commitment. Accessible here, once you have selected "YES": _____	○	○

SECTION 9 OF 9: By applying for the DBT Training Protocol, I understand that, if accepted, I will be expected to complete the following (please review prior to submitting your application, and select ALL):

	Yes	No _____
(1) I attest that I meet ALL of the prerequisites to participate in the DBT training protocol.	○	○
(2) I agree to complete the DBT training protocol in its ENTIRITY.	○	○
(3) I acknowledge my SUPERVISOR has approved my attendance to this training protocol.	○	○
(4) You acknowledge your Program Head/Clinic Manager knows of your participation in the training AND is agreeing to clear time in your schedule to complete the entire DBT training program	○	○
(5) I acknowledge that I currently have access to Zoom with VIDEOCONFRENCING CAPABILITIES for the purposes of participating in all training days.	○	○
(6) I acknowledge that I will have consistent access to videoconferencing technology for the purposes of providing individual teletherapy to clients AND will be able to securely video.	○	○
(7) I acknowledge that I have means to provide all of my clients with access to complete the required outcome measures.	○	○

The following steps MUST be executed in order for your application to be considered (please review and select ALL):

	Yes	No
(1) Please review the Request for Application (RFA) to be aware of training expectations. You can access it here, once selecting "YES": _____	◯	◯
(2) (HIGHLY RECOMMENDED) WATCH RECORDING OF THE INFORMATIONAL WEBINAR so applicants are aware of the training expectations and time commitment. Accessible here, once you have selected "YES": _____	◯	◯
(3) SAVE ALL IMPORTANT TRAINING DATES: Three x 2-hr Team Leader Consultation: The DBT leadership are able to attend Tuesday, September 8, 2026 @ 9am-11am CDT, Tuesday, September 22, 2026 @ 9am-11am CDT, and Tuesday, October 27, 2026 @ 9am-11am CDT; 5 Half- Day Kick-off: The DBT team are able to attend October 5-9, 2026 @ 9am-1pm CDT; Online Skills: The DBT team are able to attend September 28, 2026- January 31, 2027; 3-hr program directors (Leadership orientation): The DBT clinic supervisors are able to attend leadership orientation August 14, 2026@ 9:00am-12:00pm CT; Team Consultation Calls: The DBT team is able to attend 18 bi-weekly consultation sessions for 60 minutes each September 28, 2026 – June 30, 2027; Session Tapes: The DBT team is able to attend December 4, 2026 - March 31, 2027 (contingency cushion: June 30, 2027); 3 Half- Day Booster: The DBT team are able to attend February 16-18, 2027 @9am-1pm CT; Team Case Conceptualizations: The DBT team are able to attend February 18, 2027 - June 30, 2027	◯	◯

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 DBT training. The agency agreement must be completed by SEPTEMBER 1, 2026.

You can click on this link to access the AGENCY AGREEMENT.

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

You have reached the end of the 2026 DBT Individual application.

Please review any of your responses on previous pages utilizing the "previous page" button below before submitting your application.

You will need to TYPE IN YOUR E-MAIL ADDRESS in the TEXT BOX on the next page for a PDF copy of your application responses.