Parent Child Interaction Therapy (PCIT) Application (Cohort 7)

Please complete the application below.

Warm Regards,

Center Staff

for EBP Trainings: (504) 568-5731

laevidencetopractice.com

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PCIT INDIVIDUAL APPLICATION

The PCIT online training is scheduled to begin in Fall 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 PCITApplication 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 September 7, 2026.

(2) TheAGENCY 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 SEPTEMBER 7, 2026.

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 E-mail address

_____

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
- ◯ LMHP Group Practice
- ◯ Other

Please list any other applicable agency types

_____

If other, please indicate which type

_____

(Please type in the type of agency worked at)

Please specify the agency type:

- ◯ Sole practice provider
- ◯ Agency-based provider
- ◯ Both (sole practice provider AND agency-based provider)

What is applicant's 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 (select all that apply)?

- ☐ Aetna Better Health
- ☐ Amerihealth Caritas of Louisiana
- ☐ Healthy Blue/ Anthem
- ☐ Humana Healthy Horizons
- ☐ Louisiana Healthcare Connections
- ☐ Magellan Behavioral Health

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-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

If you selected YES, please describe if this applicant works with the child or adult, family-level treatment, etc. Please limit response to 150-200 words.

_____

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

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 Alaksa 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
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
Educational Degree(s)	_____ (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 ◯ 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)
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)
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 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)	_____

SECTION 4 OF 8- TRAINING DATES

Can the applicant attend the following training dates?

	Yes, I can attend/participate	No, I cannot attend/participate
PCIT Orientation Meeting on September 30, 2026 from 11:30am-1:00pm CST.	◯	◯
Learning Session 1: PCIT 5-Day Training from October 21-23; 26-27, 2026 from 9:00AM-5:00pm CST.	◯	◯
Learning Session 2: February 25-26, 2027 from 9:00AM-5:00PM CST.	◯	◯
Consultation Call Commitment: attend 1 hour bi-weekly consultation calls for one year.	◯	◯

We highly recommend you attending in order to ensure your success in PCIT training.

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

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?

_____

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.

_____

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.

_____

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 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

It is mandated that leadership at your agency will be required to participate in leadership meetings to better support clinicians throughout the PCIT training period.

If chosen for this training opportunity, will your leadership at your agency (i.e. Clinical Director, Clinical Manager, Agency Director, etc.) be able to attend the Agency Leadership Meetings that may consist of up to four (4) hours throughout the PCIT training period?

Note: Future EBP Leadership meeting dates are accessible in the PCIT RFA on pg. 8 by clicking here:

- ◯ Yes
- ◯ No

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

_____

(Please input emails)

Would your agency leadership be also interested in auditing the PCIT training to better support clinical staff?
We HIGHLY encourage this for agency leadership to participate in auditing at least PCIT Learning Session 1 to help with long-term PCIT implementation and support.

- ◯ Yes
- ◯ No

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 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 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 Pgs. 8-9 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: _____	○	○

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	No _____
(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.

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

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

APPLICATION DEADLINE: SEPTEMBER 7, 2026

Applicants will be notified via email by SEPTEMBER 11,2026. 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 emailEvidence 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 on the next page.