TF-CBT Application (Cohort 11)

Hello,

We thank you for your interest in the TF-CBT training opportunity. The application will open on MONDAY August 3, 2026. Please check on or after that date to apply. The application will be open until AUGUST 16, 2026. You will be notified of your status by AUGUST 18, 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

for EBP Trainings: (504) 568-5731

laevidencetopractice.com

Sign-up for our newsletter!

TF-CBT INDIVIDUAL APPLICATION

The TF-CBT 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 30 practitioners.

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

Please review the TF-CBT 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 TF-CBT Application is to be completed by each applicant and can be accessed by filling out this online application. **Please note, each TF-CBT Application must upload an Agency Agreement.

This must be completed by AUGUST 16, 2026.

(2) The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the TF-CBT 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 TF-CBT APPLICATION. The deadline for completion is AUGUST 16, 2026.

BOTH FORMS MUST BE COMPLETED FOR EACH TF-CBT 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 - TF-CBT 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 TF-CBT 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," 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 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.

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 150-200 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 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	_____

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_____

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
Asynchronous Self-Paced Online Training: Eleven (11) hours of a web-based course on your own time by September 21, 2026. This course is accessible once selecting "YES " by clicking here: _____.	◯	◯
MANDATORY Pre-Requisite TF-CBT Assessment Training: August 27, 2026 from 8:00am-12:00pm CST.	◯	◯
TF-CBT Learning Session 1 Training: Sept. 22-24, 2026 from 9:00am-4:30pm.	◯	◯
TF-CBT Learning Session 2 Training: December 8-9, 2026 from 9:00am-4:30pm.	◯	◯
Consultation Calls: Attend monthly consultation calls for 12 months (Requirement: 75% participation, attending 9/12 calls).	◯	◯

We ask that you reconsider for a more successful TF-CBT application.

SECTION 5 OF 8- TF-CBT APPLICATION TRAINEE QUESTIONS

This application is to be completed by each applicant.

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.

_____

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 child/caregiver referrals. Do you anticipate any challenges in finding families who would be able to receive TF-CBT?

Please limit response to 150-200 words.

_____

What is your current caseload per week (#)? Can you add/utilize the TF-CBT practice with your current caseload/clients?

Please limit response to 150-200 words.

_____

Explain how TF-CBT would fit your agency/practice and the community you serve.

Please limit response to 150-200 words.

_____

SECTION 6 OF 8- IMPLEMENTATION SUPPORT

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

_____
(Please enter an integer)

If chosen for this opportunity, would your agency leadership be interested in attending a 1-hour TF-CBT implementation discussion BEFORE beginning TF-CBT 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 TF-CBT 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 TF-CBT Implementation Discussion:

_____
(Please input emails)

Would your agency leadership be also interested in auditing the TF-CBT training to better support clinical staff?
We HIGHLY encourage this for agency leadership to participate in auditing at least TF-CBT Learning Session 1 to help with long-term TF-CBT 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 TF-CBT 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 TF-CBT RFA by clicking this link: _____	◯	◯
(HIGHLY RECOMMENDED) COMPLETE the Introduction to TF-CBT Online Course through E2P learn 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. 7-8 for all important dates in our TF-CBT 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 TF-CBT 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 TF-CBT training protocol.	○	○
(2) I agree to complete the TF-CBT 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 TF-CBT 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: August 16, 2026

Applicants will be notified via email by August 18, 2026.

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.