Child-Parent Psychotherapy (CPP) Application for Cohort 5

Please complete the application below.

SECTION 1 OF 7- APPLICATION INSTRUCTIONS

TheCPPonline training is scheduled to begin in Fall 2026.The course instructors are Drs. Julie Larrieu and Amy Dickson for this training opportunity.
The training application requiresTWO (2) FORMS to be completed for EVERY APPLICANT,the Trainee Application, AND the Agency Agreement.

Please review the CPP Request for Applications (RFA) in its entirety for complete details about the training prior to completing an application.

You can use the following link to access theCPPRFA:
CPP-Training_RFA_Fall 2026_FINAL_UPDATED.pdf

The AGENCY AGREEMENT is a fillable PDF and can be completed using Adobe Acrobat (or a similar PDF filling/editing software) by leadership at the agency requesting participation in the CPP training. Signatures from the Clinical Supervisor and Agency Director are required to complete the agreement. The AGENCY AGREEMENT is accessible using the following link:HERE.

Note: clinicians applying from the same agency must submit the same AGENCY AGREEMENT. Sole practitioners must also submit an AGENCY AGREEMENT on behalf of themselves. Applications without an AGENCY AGREEMENT will not be considered.

Lastly, the AGENCY AGREEMENT MUST BE SUBMITTED THROUGH THE CPP APPLICATION. The deadline for completion is SUNDAY, SEPTEMBER 27, 2026.

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 - CPP 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 CPP 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 (CAC) ◯ 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)
What is your employment status with this agency?	◯ Full-time ◯ Part-time ◯ Contract ◯ Temporary ◯ Other _____
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.)
Do you currently see Louisiana Medicaid clients?	◯ Yes ◯ No
Do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.	_____
Do you see patients in a clinical setting?	◯ Yes ◯ No
Please list all insurance plans you accept for payment, including Medicare and private health policies.	_____

Are you actively treating children and adolescents? 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.	◯ Yes ◯ No
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 _____
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 select the STATE applicant is licensed to practice in	◯ LA ◯ Other _____
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 selected above, please select the two (2) regions you serve 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 to be obtained:

_____

Please specify anticipated 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 enter your LICENSE NUMBER(s) with your respective credential:

_____

Please select your Provisional License/ License Type.

- ◯ PLPC
- ◯ LPC
- ◯ LPC-S
- ◯ PLMFT
- ◯ LMFT

Indicate MONTH and YEAR of licensure or expected licensure

_____

Please enter your LICENSE NUMBER(s) with your respective credential:

_____

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 enter your LICENSE NUMBER(s) with your respective credential:

_____

Please select your Provisional License/ License Type.	◯ Provisionally Licensed Psychologist (PLP) ◯ Licensed Psychologist (LP) ◯ Licensed Specialist in School Psychology (LSSP)
Indicate the MONTH and YEAR of licensure or expected licensure	_____
Please enter your LICENSE NUMBER(s) with your respective credential:	_____
I hold the following credentials (please select all that apply):	☐ PLPC ☐ LPC ☐ LPC-S ☐ PLMFT ☐ LMFT ☐ CSW ☐ LMSW ☐ LCSW ☐ LCSW-BACS ☐ PhD ☐ PsyD ☐ 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:	_____
Are you proficient in any other languages other than English?	◯ Yes _____ ◯ No

SECTION 3 OF 7- AGENCY INFORMATION

Name of Applicant Agency	_____
Agency Street Address	_____
Agency City	_____
Agency State	◯ LA ◯ Other _____
Agency Zip Code	_____
Agency Mailing Address (if different from Agency Street Address)	_____
Agency NPI (if known)	_____

SECTION 4 OF 7- TRAINEE CPP 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 0 and 6in the past year: _____
Treatment modalities you have used: _____

Have you been selected as an ECSS Provider?	◯ Yes ◯ No
For which LDH region(s) has your agency been selected as an ECSS provider? Please select 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
What age range does your agency primarily serve?	◯ 0-6 years old ◯ 7-13 years old ◯ 14-18 years old ◯ 19-21 years old ◯ 22+ years old
Do you have child and adult therapy experience?	◯ Yes ◯ No
Do you have experience working with children and families that have a history of trauma?	◯ Yes ◯ No
Would you, as a practitioner, have access to four (4) child cases age range of birth-6 years old throughout a future 18-month training period? For those that are supervisors, it would be access to two (2) child cases age range of birth-6 years old.	◯ Yes ◯ No
Please explain (limit responses to 100 words)	_____

Would your agency provide you the time to complete the CPP pre-work (4-5 hours in length) and all necessary readings and documentation specific for CPP fidelity throughout the training?

◯ Yes
◯ No

Please explain (please limit response to 100 words)

_____

Would you have a supervisor who supports you as a practitioner?

Note: The supervisor ideally should participate in the training, along with the clinician(s), or already be a rostered CPP supervisor.

◯ Yes
◯ No

Would your supervisor be willing to join a supervisory group?

◯ Yes
◯ No

Please explain (please limit response to 100 words)

_____

Describe your agency's current sources for child/caregiver referrals. Do you anticipate any challenges in finding children and their caregivers that have a history of trauma? Please limit response to 100 words.

_____

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 100 words.

_____

Please list any EBP you completed training in, where you were first trained, and your certification status.

_____

Are you currently in training for other EBP certifications?

◯ Yes
◯ No

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

_____

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 _____

Describe the geographic area and population served at your agency. Additionally, please mention any unique characteristics of this population.
Please limit response to 100 words.

_____

Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive CPP?
Please limit response to 100 words.

_____

What is your current caseload per week? Can you add/utilize the CPP practice with your current caseload/clients?
Please limit response to 100 words.

_____

Explain how CPP would fit your agency/practice and the community you serve.
Please limit response to 100 words.

_____

SECTION 5 OF 7- IMPLEMENTATION SUPPORT

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

_____

If chosen for this opportunity, leadership from your agency will be required to attend a 1-hour CPP implementation discussion BEFORE the CPP training begins for clinicians. Has your agency leadership agreed to attend?

◯ Yes
◯ No

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

_____
(Please input emails)

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

◯ Yes
◯ No

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 CPP 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
☐ More than one of these options
☐ Other _____
(Select all that apply.)

SECTION 6 OF 7: Can the applicant participate in the following training dates?

The Center for Evidence to Practice will be sponsoring one (1) cohort of Child Parent Psychotherapy (CPP) training in Fall 2026 - Spring 2028. 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
CPP Agency Leadership Meeting: Friday, October 16, 2026 from 12pm- 1pm CDT _____	○	○
CPP Pre-work Date: Monday, October 19, 2026 from 1pm-3pm CDT _____	○	○
CPP Learning Session 1: Wednesday-Friday, November 4-6, 2026 from 8:30am-5:00pmCST {ls1_note_v2}	○	○
CPP Learning Session 2: Thursday-Friday, April 8-9, 2027 from 8:30am-5:00pmCDT	○	○
CPP Learning Session 3: Thursday-Friday, October 7-8, 2027 from 8:30am-5:00pmCDT	○	○
Consultation Call Commitment: Attend bi-weekly 1-hour consultation calls for 18 months _____	○	○

SECTION 7 OF 7- COMMITMENT FROM CLINICIAN

Please ensure to review each of the following requirements to confirm you are able to participate in the CPP 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 CPP	○	○
(4) I will review the REQUEST FOR APPLICATION (RFA) to be aware of training expectations. You can access the CPP RFA by clicking this link: _____	○	○
(5) I will watch recordings of the informational webinar so I am aware of the training expectations and time commitment. Accessible on our E2P Learn Platform: _____	○	○
(6) I will submit a TRAINEE APPLICATION	○	○
(7) I will submit an AGENCY AGREEMENT on behalf of my agency. You can access the Agency Agreement by clicking this link: _____	○	○

We highly recommend you reconsider to better prepare you for your CPP training experience.

TheAGENCY AGREEMENTis a fillable PDF and can be completed usingAdobe Acrobat (or a similar PDF filling/editing software)by leadership at the agency requesting participation in the CPP training. Signatures from the Clinical Supervisor and Agency Director arerequiredto complete the agreement. TheAGENCY AGREEMENTis accessible using the following link:HERE. The agency agreement must be completed bySUNDAY, SEPTEMBER 27,2026.

You can click on the following link to access the AGENCY AGREEMENT: HERE.

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.)

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.

Child-Parent Psychotherapy (CPP) Application for Cohort 4

Please complete the application below.

SECTION 1 OF 7- APPLICATION INSTRUCTIONS

TheCPPonline training is scheduled to begin in Fall 2025.The course instructors are Drs. Julie Larrieu and Amy Dickson for this training opportunity.
The training application requiresTWO (2) FORMS to be completed for EVERY APPLICANT,the Trainee Application, AND the Agency Agreement.

Please review the CPP Request for Applications (RFA) in its entirety for complete details about the training prior to completing an application.

You can click here to access theCPPRFA:
CPP-Training_RFA_Summer-2025_FINAL_UPDATED.pdf

The AGENCY AGREEMENT is to be completed through Adobe PDF (a fillable PDF) by leadership at the agency requesting participation in the CPP training and signed by the Administrator and Supervisor. You can access the AGENCY AGREEMENT byCLICKING HERE. The AGENCY AGREEMENT MUST BE SUBMITTED THROUGH THE CPP APPLICATION. The deadline for completion is WEDNESDAY AUGUST 20, 2025.

BOTH FORMS MUST BE COMPLETED FOR EACH CPP 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 7 - CPP 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 CPP 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 ☐ United Healthcare/Optum ☐ Other (Please select all that apply.)
Please specify.	_____
Is your agency a Child Advocacy Center?	◯ Yes ◯ No
Please specify what type of entity.	_____
Do you currently see Louisiana Medicaid clients?	◯ Yes ◯ No
Do you currently see those Medicaid clients for a minimum of 45-60 minutes psychotherapy sessions? Please describe.	_____
Do you see patients in a clinical setting?	◯ Yes ◯ No
Please list all insurance plans you accept for payment, including Medicare and private health policies.	_____
Are you actively treating children and adolescents? 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.	◯ Yes ◯ No
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
What is the highest degree completed to date?	◯ Bachelor's ◯ Master's ◯ Doctorate/PhD ◯ 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 indicate month and year)
Please select your Provisional License/ License Type.	◯ PhD ◯ PsyD
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 ☐ PhD ☐ PsyD ☐ 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 3 OF 7- 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 4 OF 7- TRAINEE CPP 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 0 and 6in the past year: _____
Treatment modalities you have used: _____

Have you been selected as an ECSS Provider?	◯ Yes ◯ No
Which LDH region? Please select 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
What age range does your agency primarily serve?	◯ 0-6 years old ◯ 7-13 years old ◯ 14-18 years old ◯ 19-21 years old ◯ 22+ years old
Do you have child and adult therapy experience?	◯ Yes ◯ No
Do you have experience working with children and families that have a history of trauma?	◯ Yes ◯ No
Would you, as a practitioner, have access to four (4) child cases age range of birth-6 years old throughout a future 18-month training period? For those that are supervisors, it would be access to two (2) child cases age range of birth-6 years old.	◯ Yes ◯ No
Please explain (limit responses to 100 words)	_____

Would your agency provide you the time to complete the CPP pre-work (4-5 hours in length) and all necessary readings and documentation specific for CPP fidelity throughout the training?

◯ Yes
◯ No

Please explain (please limit response to 100 words)

_____

Would you have a supervisor who supports you as a practitioner?

Note: The supervisor ideally should participate in the training, along with the clinician(s), or already be a rostered CPP supervisor.

◯ Yes
◯ No

Would your supervisor be willing to join a supervisory group?

◯ Yes
◯ No

Please explain (please limit response to 100 words)

_____

Describe your agency's current sources for child/caregiver referrals. Do you anticipate any challenges in finding children and their caregivers that have a history of trauma? Please limit response to 100 words.

_____

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 100 words.

_____

Please list any EBP you completed training in, where you were first trained, and your certification status.

_____

Are you currently in training for other EBP certifications?

◯ Yes
◯ No

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

_____

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: _____

Describe the geographic area and population served at your agency. Additionally, please mention any unique characteristics of this population.
Please limit response to 100 words. _____

Describe your agency's current source of referrals. Do you anticipate any challenges finding clients who would be able to receive CPP?
Please limit response to 100 words. _____

What is your current caseload per week? Can you add/utilize the CPP practice with your current caseload/clients?
Please limit response to 100 words. _____

Explain how CPP would fit your agency/practice and the community you serve.
Please limit response to 100 words. _____

SECTION 5 OF 7- IMPLEMENTATION SUPPORT

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

_____

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

_____
(Please input emails)

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

◯ Yes
◯ No

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 Unlikely
◯ Unlikely
◯ Neutral
◯ Likely
◯ Very Likely

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 Unlikely
◯ Unlikely
◯ Neutral
◯ Likely
◯ Very Likely

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 CPP 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
☐ More than one of these options
☐ Other
(Select all that apply.)

Please specify how you heard about this training opportunity:

_____

SECTION 6 OF 7: Can the applicant participate in the following training dates?

The Center for Evidence to Practice will be sponsoring one (1) cohort of Child Parent Psychotherapy (CPP) training in Spring 2025- Spring 2026. 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
CPP Pre-work Date: Monday, September 15, 2025 from 11am-1pm CST _____	○	○
CPP Agency Leadership Meeting: Monday September 8, 2025 from 12pm- 1pm CST _____	○	○
CPP Learning Session 1: October 6-8, 2025 from 8:30am-5:00pmCST _____	○	○
CPP Learning Session 2: April 9-10, 2026 from 8:30am-5:00pmCST	○	○
CPP Learning Session 3: October 7-8, 2026 from 8:30am-5:00pmCST	○	○
Consultation Call Commitment: Attend bi-weekly 1-hour consultation calls for 18 months _____	○	○

SECTION 7 OF 7- COMMITMENT FROM CLINICIAN

Please ensure to review each of the following requirements to confirm you are able to participate in the CPP 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 CPP	○	○
(4) I will review the REQUEST FOR APPLICATION (RFA) to be aware of training expectations. You can access the CPP RFA by clicking this link: _____	○	○
(5) I will watch recordings of the informational webinar so I am aware of the training expectations and time commitment. Accessible on our E2P Learn Platform: _____	○	○
(6) I will submit a TRAINEE APPLICATION	○	○
(7) I will submit an AGENCY AGREEMENT on behalf of my agency. You can access the Agency Agreement by clicking this link: _____	○	○

We highly recommend you reconsider to better prepare you for your CPP training experience.

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 CPP training. The agency agreement must be completed by August 20,2025.

You can click on this link to access the AGENCY AGREEMENT

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.)

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.