

# 2024-2025 Wisconsin Child Parent Psychotherapy (CPP) Learning Collaborative

# Application Form

# Apply by December 20, 2023 to Ensure Consideration

# *Each individual applicant within an organization completes a separate CPP Application*

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| --- | --- | --- | --- |
| First Name: | | Last Name: | |
| Degree : | License Type: | | License #: |
| Institution where Degree Obtained: | | | Year Degree Obtained: |

Have you completed the University of Wisconsin Infant, Early Childhood and Family Mental Health Certificate Program: If yes, date completed:

Have you completed a parent-infant/early childhood mental health program in another state? If yes, what was the name of your program and when did you complete it?

Current Job Title:

|  |  |  |  |
| --- | --- | --- | --- |
| Address: | | | Primary Phone: |
|  | | | Other Phone (if applicable): |
|  | | |
| City: | State: | Zip: | Email: |

Primary Role: (Select one)

Clinical Supervisor Clinician.

Secondary Role, if applicable: (Select one)

Senior Leader Clinical Supervisor Clinician Consultant. Other, specify role:

## Organization Information:

|  |  |
| --- | --- |
| Agency Name: | Website: |
| Counties served by organization: | |

Program Manager (Contact person regarding this application):

|  |  |  |  |
| --- | --- | --- | --- |
| Program Manager’s Address: | | | Program Manager’s Phone: |
|  | | |
| City: | State: | Zip: |

Program Manager’s E-mail:

Clinical Supervisor: Supervisor Phone: Supervisor E-mail:

Executive Director: Executive Director Phone: Executive Director E-mail:

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| Services Provided by the applicant: |

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| Are you expecting to fully complete this CPP Training and be Rostered?  Yes No, enrichment only Other (please describe): |

1. CPP has been demonstrated to be efficacious with children under the age of six who have experienced trauma and their primary caregivers. It is a flexible modality that may be delivered in the clinic or in the family’s home.
   1. Describe the population with whom you plan to implement CPP during the training?
   2. Please describe the setting(s) in which CPP will be implemented and types of trauma the families may have experienced.
2. What experience do you have working with infants/very young children and their caregivers?
3. What experience do you have working with adults (parents/caregivers) and families with mental health concerns and/or exposure to trauma?
4. At present, what type of therapy does your site typically provide for families seeking treatment for their young children and/or for families seeking assistance with trauma- related symptoms or experiences?
5. Please describe your training and experience using evidence-based practices in mental health treatment.
6. How do you plan to identify potential CPP clients?
7. CPP includes using assessments (e.g. trauma exposure, PTSD symptoms, parent-child relationship, parental mental health screeners) with children and caregivers at the start and end of treatment. Do you foresee any difficulties obtaining or scoring the measures?
8. Clinicians will be asked to complete and submit several fidelity forms to guide effective implementation of CPP. Do you foresee any difficulties completing these forms?
9. Briefly describe the range of diversity in the families with young children (ages 0-6) that you serve and how your work reflects an awareness and respect of cultural differences.
10. Please describe any other experiences, training, or factors that prepare you for this CPP Implementation Level Training.
11. Has your supervisor participated in the CPP Implementation Level Training or do they plan to participate in this CPP training?
12. Please describe the supervision you are currently receiving.
    1. Frequency:
    2. Duration:
    3. Format (individual, group):
    4. Type (e.g. reflective, clinical, administrative, other):

# ADDITIONAL QUESTIONS FOR APPLICANTS WHO ARE CLINICAL SUPERVISORS:

1. Describe the model that is used for clinical supervision at your site.
2. Please describe your training to provide Reflective Supervision.

## Applicant Agreement to Complete and Signature:

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| --- | --- |
| I, \_\_\_\_\_\_\_\_\_\_\_have read the requirements for training listed in the  (**Print Applicant’s Name)** CPP Training Agreement. If selected for the CPP  Training, I agree to complete the listed requirements. | |
| **Signature:** | **Date:** |

**PROPOSAL AUTHORIZATION**

|  |  |
| --- | --- |
| **Name of Applicant’s Clinical Supervisor (if Applicable)** | |
| **Signature:** | **Date:** |

**Please send your completed application to**: Bryn Abramson, Administrative Assistant by email attachment: [babramson3@wisc.edu](mailto:babramson3@wisc.edu) or mail to her attention at the UW Department of Psychiatry, 6001 Research Park Blvd, Madison, WI 53719.