RCDSO | Royal College of Dental Surgeons of Ontario

FUNDING APPLICATION

This form is to be completed by the applicant. The College's Patient Relations Committee (PRC) will review the completed application and determine whether the eligibility criteria set out in legislation has been met, and if so, the amount of funding that will be awarded.

You do not need a therapist/counsellor to apply for funding. However, you will need a therapist/counsellor in order to access any funding that has been awarded to you. Once you have chosen a therapist/counsellor, they will need to complete ***Form B****.*

Applicant information:

FIRST NAME: LAST NAME:

ADDRESS:

PHONE: EMAIL:

I prefer to be contacted by: ☐ PHONE ☐ EMAIL ☐ MAIL

I, _____ , was sexually abused by
name of applicant

Dr. _____ while I was their patient.
name of dentist

The abuse started on _____ and ended on _____ .
approximate date approximate date

I was a patient of this dentist from _____ to _____ .
approximate date approximate date

I am asking for funding for therapy and counselling as a result of this sexual abuse.

Other sources of funding (e.g., private health insurance):

_____ (name of provider) _____ (amount)

Please check the boxes that pertain to your situation:

	Yes	No	Maybe
I have chosen a therapist/counsellor.	☐	☐	☐
I have already started therapy/counselling for the sexual abuse I experienced, paid out-of-pocket for these costs and intend to seek reimbursement from the College.	☐	☐	☐

By signing this document, I acknowledge and agree to the following:

1. I understand that the Patient Relations Committee (PRC) will decide whether I meet the eligibility criteria set out in legislation for this funding.
2. I understand that a decision by the PRC that I am eligible for funding does not mean the above-named dentist has been found guilty and will not be considered by any other committee of the College.
3. I understand that if I'm eligible for funding, the PRC will decide how much funding will be awarded and I will have five years to use the funding. The five-year period will begin on the date the PRC determined I was eligible for funding, or if I request reimbursement for past costs, the date I first received therapy/counselling for the alleged sexual abuse, whichever is earlier.
4. I understand that my therapist/counsellor will need to meet the requirements set out in legislation, including:
    A. The therapist/counsellor cannot be in a family relationship with me or have any other potential conflict of interest. I understand and agree that the term "family relationship" includes any family relationship established through marriage.
    B. The therapist/counsellor cannot at any time, or in any jurisdiction, have been found guilty of professional misconduct of a sexual nature, or have been found liable, criminally or civilly, for an act of a sexual nature.
5. I understand that if I choose a therapist/counsellor who is not a regulated health professional, they are not subject to professional oversight by the College or any other regulatory body.
6. I understand that:
    - Funding can only be used for therapy/counselling.
    - All payments for therapy/counselling will be made directly to the therapist/counsellor.
    - There will be no payment for late or missed appointments.
7. I understand that other sources of funding for therapy/counselling must be used first, such as public health insurance (i.e., OHIP) or private health insurance, and there can be no duplicate payment for the same service. I consent to the College contacting my therapist/counsellor or my private health insurance provider(s) to determine how much funding I am eligible for.
8. I understand that I will need to complete **Form C** if I want to request reimbursement for therapy/counselling costs I personally paid for out-of-pocket.
9. I undertake to keep confidential all information obtained through the application for funding process and refrain from using this information for any other purpose.

Signature of applicant

Date (YYYY – MM – DD)

How to submit the form(s)

Email us
patientrelations@rcdso.org

OR

Print the form and mail it to us at
RCDSO Attn. PRC
6 Crescent Road, Toronto, ON M4W 1T1

12/23_5464

FORM B

RCDSO | Royal College of Dental Surgeons of Ontario

THERAPIST/COUNSELLOR INFORMATION FORM

This form is to be completed by the therapist/counsellor. The Patient Relations Committee (PRC) follows the rules and regulations made into law by the Government of Ontario, which direct the College in administering this funding program. This form is to be completed once the applicant has chosen a therapist/counsellor and is required before funding can be provided.

Therapist/Counsellor Information:

NAME OF THERAPIST/COUNSELLOR:

PRACTICE NAME (if applicable):

PRACTICE ADDRESS:

BILLING ADDRESS:
(if different from practice address):

PHONE: EMAIL:

HOURLY RATE:

I, _____ (the therapist/counsellor) , am providing, or propose to provide, therapy and counselling to _____ (the applicant) , under the funding program established by the Royal College of Dental Surgeons of Ontario (the College).

Please check the boxes that pertain to your situation:

☐ I became a member of _____ Regulatory College in _____ (year) .
My registration number is _____ .

☐ I ceased to be a member of _____ Regulatory College in _____ (year) .

☐ I have never been a member of a regulated health profession.

By signing this document, I acknowledge and agree to the following:

1. I understand that the PRC will decide if the applicant is eligible for funding and if eligible, how much funding will be awarded.
2. I understand that eligible applicants will have five years to use the funding. The five-year period will begin on the date the PRC determined the applicant was eligible for funding, or if the applicant requests reimbursement for past costs, the date the applicant first received therapy/counselling for the alleged sexual abuse, whichever is earlier.
3. I understand that funding can only be used for therapy/counselling, all payments for therapy/counselling will be made directly to me, and there will be no payment for late or missed appointments.
4. I understand that other sources of funding for therapy/counselling must be used first, such as public health insurance (i.e., OHIP) or private health insurance, and there can be no duplicate payment for the same service.
5. To my knowledge, no other sources of funding for the therapy/counselling are available to the applicant, or the following additional sources of funding for therapy/counselling are available to the applicant:

   _____ _____ .
   Name of provider Amount available
6. If at any time other sources of funding become available to the applicant, I shall notify the College and, where appropriate, deduct the amount that has been funded by another source on any subsequent invoices to the College or cease submitting invoices to the College if the other source of funding covers the entire amount.
7. If the applicant is submitting a request to be reimbursed for past therapy costs (**Form C**), I agree to reimburse the applicant directly in return for funds that are received from the College.
8. I understand that I have to complete **Form D** every time I submit an invoice to the College.
9. I do not have any family relationship with the applicant. I understand and agree that the term "family relationship" includes any family relationship established through marriage. I do not know of any other conflict of interest or potential conflict of interest.
10. I have not, at any time, or in any jurisdiction, been found guilty of professional misconduct of a sexual nature, or have been found liable, criminally or civilly, for an act of a sexual nature.
11. If applicable, I have explained to the applicant that I am not a regulated health professional and I am not subject to professional oversight by the College or any other regulatory body.
12. I will keep confidential all information obtained through the application for funding process and will refrain from using that information for any other purpose.
13. I confirm that the information contained in this form is correct to the best of my knowledge and will update the College if any of the information in this form changes.

_____ _____
Signature of Therapist/Counsellor Date (YYYY – MM – DD)

How to submit the form(s)

Email us
patientrelations@rcdso.org

OR

Print the form and mail it to us at
RCDSO Attn. PRC
6 Crescent Road, Toronto, ON M4W 1T1

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