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

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REQUEST FOR PAST THERAPY/COUNSELLING COSTS

This form is completed by the applicant. The College may reimburse applicants for past therapy/counselling costs they personally incurred in the following circumstances:

- *the therapy/counselling was provided any time after the alleged sexual abuse took place;*
- *the past therapy/counselling costs have not been paid by any provider;*
- *the applicant or therapist/counsellor provides invoices or receipts with therapy dates and costs; and*
- *the therapist/counsellor agrees to reimburse the applicant, in return for funds paid directly to the therapist/counsellor.*

Applicant information:

FIRST NAME: LAST NAME:

ADDRESS:

PHONE: EMAIL:

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

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

_____ (name of provider) _____ (amount)

Therapist/Counsellor Information:

NAME OF THERAPIST/COUNSELLOR:

PRACTICE NAME (if applicable):

PRACTICE ADDRESS:

BILLING ADDRESS:
(if different from practice address):

PHONE: EMAIL:

Therapy/Counselling Information:

Dates of therapy/counselling sessions (YYYY – MM – DD)	Amount of session	Amount requested (if different from amount of session)

TOTAL AMOUNT REQUESTED: $ _____

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

1. I am claiming reimbursement for therapy/counselling sessions that occurred after the alleged sexual abuse. All costs associated with these sessions were for my therapy/counselling.
2. I have used all other sources of funding available to me before claiming reimbursement for these past therapy/counselling costs.
3. I paid out-of-pocket for these past therapy/counselling costs and have not already been reimbursed for them. I understand that there can be no duplicate payment for the same service.
4. I am, or my therapist/counsellor is, providing receipts or invoices for the past therapy/counselling costs I am seeking reimbursement for.
5. I understand that my therapist/counsellor has to agree to reimburse me, in return for funds that the College will pay directly to the therapist/counsellor.
6. My therapist/counsellor meets the requirements set out in legislation, including:
    A. My therapist/counsellor is not in a family relationship with me or does not 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 has not, at any time, or in any jurisdiction, been found guilty of professional misconduct of a sexual nature, or been found liable, criminally or civilly, for an act of a sexual nature.
7. I undertake to keep confidential all information obtained through the application for funding process and refrain from using this information for any other purpose.
8. 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 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
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6 Crescent Road, Toronto, ON M4W 1T1

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