

FUNDING FOR THERAPY AND COUNSELLING FOR PATIENTS WHO HAVE BEEN SEXUALLY ABUSED

The Royal College of Dental Surgeons of Ontario (the College) provides funding for therapy and counselling for patients who allege that they were sexually abused by a dentist.

How do I know if I am eligible for funding?

If you have experienced sexual abuse by a dentist, you can apply for funding for therapy and counselling by completing **Form A**. Sexual abuse is defined in the [legislation](#) as:

- sexual intercourse or other forms of physical sexual relations between the dentist and the patient;
- touching, of a sexual nature, of the patient by the dentist; or
- behaviour or remarks of a sexual nature by the dentist towards the patient.

The College's Patient Relations Committee (PRC) will review **Form A** to determine if it meets the eligibility criteria set out in legislation (the [Health Professions Procedural Code](#), Schedule 2 of the *Regulated Health Professions Act, 1991*, and the [General Regulation](#) enacted under the *Dentistry Act, 1991*).

Most applications will fall under the following eligibility criterion:

- It is alleged, in a complaint or report, that the person was sexually abused by a dentist while the person was a patient of the dentist.

You do not have to meet with the PRC as they only review the documentation that has been submitted.

Is there a time limit to apply for funding?

You can apply for funding for therapy and counselling at any time. You do not have to wait until a parallel investigation (i.e., College investigation of a complaint or report, police investigation) or the College's discipline process has concluded as these processes are separate and distinct from the funding program.

How much funding is available?

The PRC will determine how much funding for therapy and counselling will be awarded for eligible applicants. The maximum amount of funding for therapy/counselling that can be provided is approximately \$17,000.

The funding is paid by the College directly to the therapist/counsellor on behalf of the eligible applicant.

Do I need to have a therapist/counsellor to apply for funding? How do I find a therapist/counsellor?

You do not need to have 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.

You can find a therapist/counsellor by searching the College registers of other regulated professionals. For example:

- [College of Nurses of Ontario](#)
- [College of Physicians and Surgeons of Ontario](#)
- [College of Psychologists of Ontario](#)
- [College of Registered Psychotherapists of Ontario](#)
- [Ontario College of Social Workers and Social Service Workers](#)

You can also choose a therapist/counsellor who is unregulated, provided that they meet the requirements in legislation, but this means that they will not be subject to professional oversight by the College or any other regulatory body.

Once you have found a therapist/counsellor, they will have to complete **Form B**. This form sets out the legislative requirements for therapists/counsellors and the funding program.

Where can I find the application form and other relevant forms?

The funding program forms are posted on the College's [website](#) and can be found in this application package:

- **Form A: Funding Application**
 - This is the only form you need to complete to apply for funding for therapy and counselling.
- **Form B: Therapist/Counsellor Information**
 - The therapist/counsellor completes this form once you have chosen one.
- **Form C: Request for Past Therapy/Counselling Costs**
 - You complete this form to request reimbursement for therapy/counselling costs you personally paid for out-of-pocket.
- **Form D: Therapy/Counselling Invoice Submission**
 - The therapist/counsellor completes this form every time they submit an invoice to the College.

Questions?

Contact us by [email](#) or phone at 416-961-6555 or toll-free at 1-800-565-4591

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

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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, _____, am providing, or propose to provide,
the therapist/counsellor
therapy and counselling to _____, under the
the applicant
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

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)

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THERAPY/COUNSELLING INVOICE SUBMISSION

The therapist/counsellor must sign and submit a copy of this form with each invoice for therapy/counselling provided.

None of the information provided by me in **Form B** (Therapist/Counsellor Information Form) has changed, except for the following:

Signature of Therapist/Counsellor

Date (YYYY – MM – DD)

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the form(s)**

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