FUNDING FOR THERAPY AND COUNSELLING FOR PATIENTS WHO ARE ALLEGING SEXUAL ABUSE OR WHO HAVE BEEN SEXUALLY ABUSED BY A DENTIST

The Royal College of Dental Surgeons of Ontario (the College) provides funding for therapy and counselling for patients who have made allegations of sexual abuse by a dentist or where there has been a finding of sexual abuse by a dentist.

Who is eligible?

Funding is provided for therapy and counselling that occurred after the alleged sexual abuse took place. The funding is paid directly to the therapist by the College. Patients are eligible if:

- they have filed a complaint alleging sexual abuse
- they are part of a Registrar's investigation into allegations of sexual abuse
- there has been a finding of sexual abuse by a Discipline Committee panel.

If there is an appeal of a panel's findings, the therapy funding is not affected.

A patient's eligibility does not constitute a finding against the dentist and shall not be considered by any other committee.

How much funding is available?

The maximum amount will depend on the specific circumstances, but it is approximately $17,000. Once the patient's eligibility is determined and the application processed, the College will let the patient know what amount they will receive for treatment. If some of the cost of the therapy and counselling is paid for by the Ontario Health Insurance Plan (OHIP) or a private insurer, the amount of College funding will be reduced by that amount.

Is there a time limit to apply?

Funding may be provided for up to five years from the date the patient became eligible or the date they first received therapy and counselling. To receive the full benefit of the funding, patients should submit their application as early as possible.

Can the patient choose the therapist or counsellor?

If the patient is eligible for funding they may choose any therapist or counsellor as long as the therapist or counsellor:

- is not a family member
- has not been found guilty of sexual misconduct or been found civilly or criminally liable for a similar act
- signs a document to confirm that they are not subject to professional discipline if they are a regulated health professional.

How do patients apply?

Application forms are posted on the College's website. Patients can also contact the College's Sexual Abuse Protocol Officer for assistance by calling the RCDSO: 416-961-6555.

Form A
Application for Funding for Therapy and Counselling

Form B
Therapist/Applicant Information Form

Form C
Request for Past Therapy Costs

Form D
Therapy Invoice Submission

Royal College of
Dental Surgeons of Ontario

6 Crescent Road, Toronto, ON Canada M4W 1T1
T: 416.961.6555 F: 416.961.5814 Toll Free: 1.800.565.4591 www.rcdso.org

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FORM A
APPLICATION FOR FUNDING FOR THERAPY AND COUNSELLING

My name is ______________________________

I was Dr. ______________________________ (the dentist) patient

from ____________________ (date) to ____________________ (date)

I was sexually abused by Dr. ______________________________ (the dentist) while I was their patient.

The abuse started on ____________________ (date) and ended on ____________________ (date)

I am asking for funding for therapy and counselling as a result of this sexual abuse.
I understand that the Patient Relations Committee will decide whether I qualify for this funding.
I understand that all payments will be made directly to the therapist/counsellor.

1. I am seeking funding for therapy and counselling that (choose one):

   - ☐ started on ____________________ , before I told the College about the abuse and the therapy is continuing.
   - ☐ started on ____________________ , after I told the College about the abuse.
   - ☐ has not started yet.
   - ☐ Other ______________________________

2. My therapist/counsellor for the purposes of the Program are:

   1. ______________________________
   2. ______________________________

3. I do not have a family relationship with my therapist/counsellor. I understand and agree that the term “family relationship” includes any family relationship established through marriage.

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4. I have provided contact information for my therapist/counsellor, any other therapist/counsellor who has provided me with therapy and counselling related to this matter in the past, and my private health insurance provider(s). I understand that the College may contact these individuals or companies to determine how much funding I am eligible for.

5. I understand that my therapist or counsellor and I will need to complete a Therapist/Applicant Information Form (Form B).

Dated this ______________________ day of ________________________ , 20 ____ .

____
Signature of Applicant

____
Print name

Applicant's contact information:

PHONE: ______________________ EMAIL: ______________________

ADDRESS: ____

____

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FORM B
THERAPIST/APPLICANT INFORMATION FORM

The Patient Relations Committee 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 and is required before funding can be provided.

The therapist must complete Part I and the applicant must complete Part II.

Part I – To be completed by the therapist

I, ____ , (the therapist) am providing or propose to provide therapy and counselling to:

____ (the applicant), who is applying for funding under the program established by the Royal College of Dental Surgeons of Ontario (the College).

I declare that:

1. I am not related to the applicant through family or by marriage. I do not know of any conflict of interest or any other potential conflict of interest.

2. I understand that funding provided by the College may only be used to pay for therapy and counselling and is determined by the College's Patient Relations Committee.

3. I understand that the maximum amount of funding payable to any therapist approved under this or any other application to the College is the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. Unless retroactive funding is requested (Form C), payment for services provided will begin on the day that the Patient Relations Committee determines that the applicant is eligible for funding.

4. My hourly rate for this patient is $ _____________ .

5. If submitting a request for past therapy costs (Form C), I agree to reimburse the applicant directly in return for funds that are received from the College.

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6. ☐ I became a member of ______________________ in __________ .
Regulatory Body — Year

☐ I ceased to be a member of ______________________ in __________ .
Regulatory Body — Year

or

☐ I have never been a member of a regulated health profession. I have explained to the applicant that I would not be subject to professional oversight by any regulatory body.

7. To my knowledge, no other sources of funding for the therapy and counselling are available to the applicant, or to my knowledge, the following additional sources of funding for therapy and counselling are available to the applicant: ______________________
Name of Provider and Amount Available

If at any time other sources of funding become available to the applicant, I shall notify the College and, where appropriate, cease submitting claims to the College. I understand that there can be no duplicate payment for the same service.

8. I have not, at any time in any jurisdiction, been found guilty of professional misconduct of a sexual nature.

9. I have never been found liable, criminally or civilly, for an act of a sexual nature.

10. I will keep confidential all information obtained through the application for funding process, including that funding has been granted and the reasons given by the Patient Relations Committee. I will refrain from using that information for any collateral or other purpose.

11. I understand there will be no payment by the College for fees related to late or missed appointments.

______________________ ______________________
Signature of Therapist Date

Part II – To be completed by the applicant

I have read and acknowledge the information provided by the therapist/counsellor.

______________________ ______________________
Signature of Applicant Date

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FORM C
REQUEST FOR PAST THERAPY COSTS

Under some conditions, the College may help to pay for past therapy.
To qualify:

- *past therapy must not have been paid by any provider;*
- *the therapy must have taken place after the reported abuse;*
- *the applicant or therapist must provide invoices or receipts with therapy costs and dates;*
- *the therapist must agree to reimburse the applicant, in return for funds paid directly to the therapist.*

Dates of therapy: ____

Amount requested: $ ______________ .

Information regarding the therapist who provided these services:

NAME: ____

ADDRESS: ____

____

PHONE: ______________________ EMAIL: ______________________

Payment for these services has not been paid by OHIP or a private insurer, nor are these services eligible for such payment. Invoices or receipts are attached. All costs were for my therapy.

______________________ ______________________
Signature of Applicant Date

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FORM D
THERAPY INVOICE SUBMISSION

The therapist 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/Applicant Information Form) has changed, except for the following:

Signature of Therapist

Date

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