FUNDING FOR THERAPY AND COUNSELLING FOR SEXUAL ABUSE VICTIMS

After the Discipline Committee of the College finds that a patient has been sexually abused by a dentist, that patient can apply for funding from the College to help pay for therapy.

The funding is paid directly to the therapist. It is meant for therapy required as a result of the sexual abuse.

How long does a patient have to apply for funding?

According to the law, the funding is available for a five-year period that starts on the earlier of the following dates:

- the date that the person first received therapy related to the sexual abuse (the therapy can take place at any time after the abuse occurred) for which the person is requesting funding

or

- the date that the Discipline Committee found that the dentist committed sexual abuse.

To receive the full benefit of the funding, applicants should submit their applications as early as possible.

Who can be the therapist?

There are only two restrictions about who can be a patient's therapist:

- they must not be a member of the patient's family
- they must not have been found to have committed professional misconduct of a sexual nature or be found to be civilly or criminally liable for a similar act.

How much funding can an abuse victim receive from the College?

The government has set out a formula for calculating the amount of funding that a sexual abuse victim is eligible to receive for therapy. While the maximum amount will vary depending on specific circumstances, it is approximately $10,000.

Once a patient's eligibility is determined and the application is processed, the College will notify the applicant of the amount of funding they will receive.

How can someone apply for funding?

If the College's Discipline Committee has found that the dentist committed sexual abuse, you will be notified by the College. You can then complete and send in the forms enclosed, or contact the College's Sexual Abuse Protocol Officer to have the forms sent to you.

Forms

Form "A"
Application for Funding for Therapy and Counselling

Form "B"
Information Release Form

Form "C"
Therapist/Applicant Information Form

Form "D"
Request for Reimbursement of Past Therapy Costs

Form "E"
Therapy Invoice Submission

Royal College of Dental Surgeons of Ontario

Ensuring Continued Trust

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

I _____ , hereby apply for funding for therapy and/or counselling under the program established by the Royal College of Dental Surgeons of Ontario ("College") and administered by the College's Patient Relations Committee, pursuant to section 85.7 of the *Health Professions Procedural Code* of the *Regulated Health Professions Act, 1991* ("Program").

I was sexually abused by Dr. _____ (member of the College) while I was his patient.

The time period that this abuse occurred was approximately from _____

to _____ .

I confirm that the therapy or counselling, for which I am requesting funding is related to this sexual abuse.

I understand that any funding for therapy and counselling is always subject to the conditions and limitations applicable to the Program, as set out in the legislation, the regulations and as decided by the College's Patient Relations Committee.

I understand that the legislation requires that any and all payment by the College is made directly to the therapist/counsellor.

1. I am seeking funding for therapy or counselling that either (select one):

- ☐ commenced on _____ , which is after the abuse occurred but before the finding of the Discipline panel; or
- ☐ commenced on _____ , which is after the finding of the Discipline panel; or
- ☐ has not yet commenced
- ☐ other (please refer to attached regulation and enclose a letter of explanation – please note that to be eligible for funding for therapy or counselling, you must meet the criteria set out in the Program and as specified by Ontario Regulation 205/94 made under the Dentistry Act, a copy of which is attached to this form)

2. _____ shall be my therapist/counsellor for the purposes of the Program.

3. I confirm that I do not have a family relationship with my therapist/counsellor. I understand and agree that the term "family relationship" includes any family relationship created though marriage.

4. To assist the College in processing this application, I have completed the release of information form (Form "B") and provided the College with contact information for my therapist counsellor, any other therapist or counsellor who has provided me with therapy or 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, from time to time, to assist in determining the amount of funding for which I am eligible.

5. I understand that once a determination has been made on my eligibility, my therapist or counsellor and I will be required to complete a Therapist/Applicant Information Form (Form "C").

6. I understand that a decision by the Patient Relations Committee that I am eligible for funding does not constitute a finding of guilt against the dentist named above and shall not be considered by any other Committee of the College dealing with him/her.

Dated this _____ day of _____ , 20 ___ .

_____

Signature of Applicant

_____

Print Name

Applicant's contact information:

Phone Email

Address

Excerpt from the *Dentistry Act, 1991*
Ontario Regulation 205/94

Part II - Funding For Therapy And Counselling

6. In this Part, "member" includes a former member. O. Reg. 186/99, s. 1.

7. The Patient Relations Committee shall determine whether a person is eligible for funding under clause 85.7 (4) (a) of the Health Professions Procedural Code or under section 8. O. Reg. 186/99, s. 1.

8. (1) For the purposes of clause 85.7 (4) (b) of the Health Professions Procedural Code, the alternative requirements for a person to be eligible for funding for therapy and counselling are,

(a) that the person must submit to the Patient Relations Committee a completed application form provided by the Committee which shall include the name of the member whose conduct may entitle the person to funding; and

(b) that any of the circumstances described in subsection (2) exist. O. Reg. 186/99, s. 1.

(2) The circumstances in which a person may be eligible for funding are as follows:

1. There is an admission by a member, as part of a statement to or an agreement with the College, that the person, while a patient, was sexually abused by the member.
2. There is a finding by a court that the person, while a patient, was sexually assaulted, within the meaning of the *Criminal Code* (Canada), by a member.
3. There is a finding made by a panel of the Discipline Committee on or after December 31, 1993 that conduct of a sexual nature had occurred between the person and a member before December 31, 1993, while the person was a patient of the member, and that such conduct resulted in a finding of professional misconduct or incompetence against the member.
4. There is an allegation that the person was sexually abused by a member while a patient of the member, which allegation has been referred to a panel of the Discipline Committee for a hearing but the hearing is not held for one of the following reasons:
    i. The member has died or the College believes that the member may have died or that the member cannot be located.
    ii. The member is incapacitated.
    iii. The member's certificate of registration was revoked for misconduct of a sexual nature toward a patient before the allegations in respect of the person were heard by a panel of the Discipline Committee. O. Reg. 186/99, s. 1.

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FORM "B"

Information Release Form For Request For Funding Of Therapy

I _____ , hereby authorize and direct the persons/facilities named below to provide the Royal College of Dental Surgeons of Ontario with information, either written or oral, including, but not limited to, reports, records and documentation, and copies thereof from the records they have in respect to me. This information is to be used by the Patient Relations Committee in fulfilling its responsibilities under sub-section 85.7 of the *Health Professions Procedural Code* of the *Regulated Health Professions Act.*

NAME	ADDRESS	PHONE

_____ _____

Signature
(Please print name below)

Date

_____

Witness
(Please print name below)

Excerpt from the *Regulated Health Professions Act*

Funding provided by College

85.7 (1) There shall be a program, established by the College, to provide funding for therapy and counselling for persons who, while patients, were sexually abused by members. 1993, c. 37, s. 23.

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FORM "C" - THERAPIST/APPLICANT INFORMATION FORM

Therapist Or Counsellor Information

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 identified a Therapist and is required before payment can be made. The Therapist is to complete Part I and the Applicant is to complete Part II.

Part I – To be completed by the Therapist

I, _____ , (the "Therapist") am providing/
Name of Therapist (please print)

propose to provide therapy or counselling to _____
Name of Applicant (please print)

(the "applicant"), who is applying for funding under the program established by the Royal College of Dental Surgeons of Ontario (the "College"). I declare as follows:

1. I do not have any family relationship to the Applicant or any other potential conflict of interest. I understand that family relationship includes a relationship through marriage.

2. I understand that funding may only be used to pay for therapy or counselling to be determined by the 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 D)**, 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. To my knowledge, neither OHIP nor any private insurer is required to pay for the therapy or counselling I propose to/provide to the Applicant.

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 discipline by any regulatory body.

7. To my knowledge, no other sources of funding for the therapy or counselling are available to the

   Applicant except the following: _____ .
   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 of 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. Attached is a copy of my curriculum vitae and a summary of my training and experience, particularly with respect to my ability to provide therapy or counselling to survivors of sexual abuse.

11. I undertake to keep confidential all information obtained through the application for funding process, including, if funding is granted, the fact that funding has been granted and the reasons given by the Patient Relations Committee for granting the funding, and to refrain from using that information for any collateral or other purpose.

12. I understand there will be no payment by the College for late or missed appointments.

_____ _____

Date — Signature of Therapist

Part II – To Be Completed By The Applicant

1. I do not have any family relationship to the Therapist or any other potential conflict of interest. I understand that family relationship includes a relationship through marriage.

2. I understand that if I choose a therapist or a counsellor who is not a regulated health professional, the therapist is not subject to professional discipline by any regulatory body.

3. I understand that funding shall be paid only to the Therapist, and that it shall be used only to pay for therapy or counselling for the sexual abuse that made me eligible for the funding and shall not be applied directly or indirectly for any other purpose.

4. I understand that funding may only be used to pay for therapy or counselling provided as the Patient Relations Committee shall determine, in accordance with the law.

5. 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 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. Unless retroactive funding is requested (**Form D**), payment for services provided will begin on the day that the Patient Relations Committee determines that the Applicant is eligible for funding.

6. I will use the other sources of funding for therapy or counselling that are available to me first.

   This includes: _____ for _____ .
   Name of Insurer $ Amount

7. I understand that there can be no duplicate payment for the same service. To my knowledge, neither OHIP nor any public/private insurer is required to pay for the therapy or counselling I receive from the Therapist.

   If at any time, OHIP or a private insurer becomes required to pay for the therapy or counselling, I shall notify the College.

8. I have read and understood Part I of this form that has been completed by the Therapist including the summary of his/her training and experience.

9. I undertake to keep confidential all information obtained through the application for funding process, including, if funding is granted, the fact that funding has been granted and the reasons given by the Patient Relations Committee for granting the funding, and to refrain from using that information for any collateral or other purpose.

10. I understand there will be no payment for late or missed appointments.

Date

Signature of Applicant

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FORM "D"

Request For Reimbursement Of Past Therapy Costs

The patient Relations Committee considers requests for reimbursement of past therapy costs if certain conditions can be met – specifically, the past therapy must not have been paid by any provider, the dates of therapy must have occurred after the dates of the reported abuse, and the Applicant or Therapist must provide invoices or receipts to verify the therapy costs and dates. Since the legislation prevents us from paying the applicants directly, arrangements must be made to pay the Therapist, who must then be willing to reimburse the Applicant.

Dates of therapy _____ to _____ .
Beginning End

Amount requested: $ _____ .

Information regarding the Therapist who provided these services:

Name _____

Address _____

_____

Phone _____

By signing this form, I confirm that payment for these services has not been paid by OHIP or a private insurer, nor are these services eligible for such payment.

Please attach invoices or receipts. Please note that we can only reimburse past therapy costs that were personally incurred by the Applicant.

_____
Signature of Applicant

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FORM "E"

Therapy Invoice Submission

The Patient Relation Committee requires the therapist to sign this form when he/she submits an invoice for therapy/counselling provided. This form provides that none of the information agreed to by the therapist in Form C has changed since it was originally signed by the therapist. The Committee recommends that the therapist photocopy the Form so it can be used for all invoicing.

I agree that none of the information provided by me in Form C (Therapist/Applicant Information form) has changed.

_____
Therapist Signature

_____
Date

If any information has changed please elaborate:

_____

_____

_____

_____

_____

_____

_____

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