College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Application for FUNDING for SUPPORTIVE MEASURES

FORM 2 In accordance with the *Health Professions Procedural Code*, the College of Respiratory Therapists of Ontario (CRTO) will provide funding for therapy/counselling to an individual who submits a complaint alleging they were sexually abused by a Respiratory Therapist. The funding for therapy/counselling is equivalent to 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. (The CRTO may also reimburse an individual for specified non-therapeutic expenses related to treatment stemming from the alleged abuse.)

This form is to be completed once the applicant has identified the therapist(s) or counsellor(s) who will be providing care to them. The form must be completed in its entirety before payment can be made; one form per therapist or counsellor. The therapist or counsellor must complete Part A and the patient/client must complete Part B. For more information, refer to the Funding for Supportive Measures Policy (for Patients/Clients or Non-Patients/Clients).

PART A: COUNSELLOR or THERAPIST

FIRST NAME	LAST NAME
BUSINESS ADDRESS	
CITY	PROVINCE
POSTAL CODE	EMAIL
PHONE NUMBER	ALTERNATE PHONE
My hourly rate for this patient is: $	Registration # with Regulatory College:

DECLARATIONS

- ☐ I am not related to the applicant through family or by marriage. I do not know of any conflict of interest of any other potential conflict of interest.
- ☐ I understand that funding provided to me by the CRTO for therapy/counselling may only be applied to therapy or counselling.
- ☐ I understand that the maximum amount of funding payable to any therapist/counsellor approved by the CRTO Patient Relations Committee is limited to 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.
- ☐ I have not, at any time, in any jurisdiction, been found guilty of professional misconduct of a sexual nature.
- ☐ I have never been found liable, criminally or civilly, for an act of a sexual nature.
- ☐ I have attached a copy of my curriculum vitae and a summary of my training and experience, particularly with respect to my ability to provide therapy and counselling to survivors of sexual abuse.
- ☐ 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 CRTO Patient Relations Committee. I will refrain from using that information for any other purposes.
- ☐ I understand there will be no payment by the CRTO for fees related to late or missed appointments.

➲ **SIGNATURE** _____ **DATE** _____

PART B: APPLICANT or PATIENT / CLIENT

FIRST NAME	LAST NAME
STREET ADDRESS	
CITY	PROVINCE
POSTAL CODE	COUNTRY
PHONE NUMBER	EMAIL

My first appointment with the therapist or counsellor is / was scheduled for:

DECLARATIONS

- ☐ I am not related to the therapist or counsellor through family or by marriage. I do not know of any conflict of interest of any other potential conflict of interest.
- ☐ I understand that funding provided to me by the CRTO for therapy/counselling will be paid directly to the therapist or counsellor.
- ☐ I understand that the maximum amount of funding payable to any therapist/counsellor approved by the CRTO Patient Relations Committee is limited to 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.
- ☐ I understand that if I choose a therapist or counsellor who is not a regulated healthcare professional that the therapist/counsellor is not/will not be subject to professional discipline by a regulatory college (e.g., College of Physicians and Surgeons of Ontario, or College of Psychologists of Ontario).
- ☐ I agree that I will use other sources of funding for therapy or counselling that are available to me (e.g., OHIP or private insurance) first, before the CRTO's funding.
- ☐ I understand that there can be no duplicate payment for the same service (i.e., therapy or counselling). If at any time OHIP or a private insurer is willing to pay for the therapy or counselling I agree to notify the CRTO immediately.
- ☐ I understand there will be no payment by the CRTO for fees related to late or missed appointments.

SIGNATURE _____ **DATE** _____

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