College of Respiratory Therapists of Ontario

Ordre des thérapeutes respiratoires de l'Ontario

Application for FUNDING

FORM A TO BE COMPLETED BY THE APPLICANT

The CRTO maintains a program to provide funding for therapy and counselling to patients who allege that they were sexually abused by a Member of the CRTO. For more information, please refer to the Funding for Therapy Fact Sheet. The Patient Relations Committee (PRC) oversees the funding for therapy and counselling program.

The Applicant does not need a therapist/counsellor in order to apply for funding. If the Applicant already has a therapist/counsellor they should ask them to complete **Form B**.

1. APPLICANT INFORMATION

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

2. RESPIRATORY THERAPIST INFORMATION (if known)

FIRST NAME	LAST NAME
CRTO REGISTRATION NO.	

3. THERAPIST/COUNSELLOR CONTACT INFORMATION (if available)

FIRST NAME	LAST NAME
PRACTICE ADDRESS	
CITY	PROVINCE
POSTAL CODE	COUNTRY
PHONE NUMBER	EMAIL
REGISTRATION NO.	

Is this therapist/counsellor a regulated health professional (e.g., psychologist or psychiatrist)?	☐ YES*	☐ NO	☐ I don't know
If YES, please specify the profession:			
Are the services of this therapist/counsellor covered by OHIP or another insurer?	☐ YES*	☐ NO	☐ I don't know

If you have more than one therapist/counsellor, please provide their information on a separate form.

4. DECLARATION

1. I understand that a decision by the Patient Relations Committee of my eligibility for funding does not constitute a finding of professional misconduct against the Member of the CRTO that I have alleged sexually abused me.
2. I understand that the maximum amount of funding available to me is equivalent to the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.
3. I understand that the funding is to be reduced by the amount that OHIP or a private insurer is required to pay for therapy or counselling.
4. I understand that any funding payments will be made directly to the therapist/counsellor.
5. I understand that the funding should be used only to pay for therapy and counselling and should not be applied directly or indirectly for any other purpose.
6. I understand that there will be no payment for late or missed appointments.
7. I do not have a family or personal relationship with the therapist/counsellor or any other potential conflict of interest.
8. I understand that if the therapist/counsellor is not a member of a regulated health profession, the therapist/counsellor is not subject to professional regulatory oversight by any regulatory body.
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 to refrain from using that information for any other purpose.
10. I declare/hereby certify that the statements made on this form are complete and correct to the best of my knowledge and belief.
11. I consent to the CRTO contacting the therapist/counsellor listed on this application for the purpose of processing my application for funding.

5. SIGNATURE

APPLICANT SIGNATURE: DATE:

Completed application should be emailed to officeofregistrar@crto.on.ca or mailed to:

Patient Relations Committee
College of Respiratory Therapists of Ontario
90 Adelaide Street West, Suite 300
Toronto, Ontario M5H 3V9

Questions? If you have further questions, please contact the CRTO office at 1-800-261-0528 or 416-591-7800 or email officeofregistrar@crto.on.ca .