**Funding for Therapy and/or Counselling Application Form**

If you’ve been sexually abused by a physiotherapist, you may qualify for financial help to see a therapist or counsellor. You can apply for funding to help pay for counselling or therapy right after filing a complaint with the College or once the College has initiated an investigation. Your application will be reviewed by staff administering the fund to confirm it meets the Patient Relations Committee’s requirements. You can learn more about these requirements on the Colleges website at https://www.collegept.org/funding-for-therapy-counselling/application-requirements.

If your application does not meet these requirements, it will be reviewed by the Patient Relations Committee.

**How to Apply**  
  
Patients may apply using the online form at <https://www.collegept.org/funding-for-sexual-abuse>or complete the following form and send by email to [fundingfortherapy@collegept.org](mailto:fundingfortherapy@collegept.org) or by mail to:

College of Physiotherapists of Ontario   
Patient Relations Committee  
c/o Regus Business Centre  
1 Dundas Street West, Eaton Centre, Suite 2500   
Toronto, Ontario M5G 1Z3 Canada  
  
**Questions?**

**If you have further questions, please contact the** Deputy Registrar & Chief Regulatory Officer **at 1-800-583-5885 ext. 225 or 416-591-3828 extension 225 or** [fundingfortherapy@collegept.org](mailto:fundingfortherapy@collegept.org)**.   
  
To learn more about the Patient Relations Program visit the College website** [www.collegept.org](http://www.collegept.org)**.**

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| **Patient Contact Information** | | | | | | |
| First Name of Patient | |  | | | | |
| Last Name of Patient | |  | | | | |
| Pronoun | |  | | | | |
| Home Address | |  | | Suite/Apt. |  | |
| City/Town | |  | | | | |
| Province | |  | | Postal Code | |  |
| Phone Number | |  | | Home  Work phone  Mobile | | |
| Email Address | |  | | | | |
| Physiotherapist Name | |  | | | | |
| **Therapist Contact Information (if known)** | | | | | | |
| First Name of Therapist | |  | | | | |
| Last Name of Therapist | |  | | | | |
| Pronoun | |  | | | | |
| Address | |  | | Suite |  | |
| City/Town | |  | | | | |
| Province | |  | | Postal Code | |  |
| Phone Number | |  | | | | |
| Email Address | |  | | | | |
| Start Date of Therapy | | (mm/dd/yyyy) | | | | |
| Is this therapist/counsellor a regulated health professional?  YES, this therapist/counsellor is a regulated health professional. NO, this therapist/counsellor is NOT a regulated health professional. I don't know | | | | | | |
| If YES, please tell us what profession they are a member of | | | | | | |
| 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 or counsellor please add their contact information: | | | | | | |
| **Confirmation and Permission to Contact** | | | | | | |
| **I confirm that:**   1. I do not have a family or personal relationship to the Therapist or Counsellor or any other potential conflict of interest. 2. I understand that if I choose a Therapist or Counsellor who is not a regulated health professional they are not subject to professional discipline by the College of Physiotherapists of Ontario or any other regulatory body. 3. I understand that funding shall be paid only to the Therapist or Counsellor, and it shall be used only to pay for therapy or counselling for the sexual abuse that made me eligible for funding and shall not be applied directly or indirectly for any other purpose. 4. I understand that the maximum amount of funding payable to any Therapist or Counsellor approved under this or any other application to the College of Physiotherapists of Ontario 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 not to exceed $17,370. 5. I will use the other sources of coverage or funding for therapy or counselling that are available to me first. 6. I understand that there can be no duplicate payment for the same service. To my knowledge OHIP or any other private insurer is not covering the costs associated with the therapy or counselling I receive from the Therapist or Counsellor. If at any time, OHIP or a private insurer can pay for the therapy or counselling, I shall notify the College of Physiotherapists of Ontario. 7. I understand that I will need to pay for any cancellation or late fees.   **By checking this box, I confirm the seven statements listed above and I agree to allow the College of Physiotherapists of Ontario to contact the above-named Therapist or Counsellor, as necessary, to process my application for funding.**  **I confirm the seven statements listed above as well as the information in this form and I allow contact.** | | | | | | |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Patient Signature* | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *Date* | | | |