Patients may choose any therapist or counsellor to provide treatment so long as the therapist or counsellor is not a relative and has not been found guilty of sexual abuse. Patients can access the funds for more than one therapist or counsellor if they so choose. Patients will be asked to keep any information about their application confidential.

**Requirements**

1. The therapist/counsellor must not be a person with whom you have any family/personal relationship.
2. The therapist/counsellor must not be a person who has at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature or been found civilly or criminally liable for an act of a similar nature.
3. If the therapist/counsellor is not a member of a regulated health profession there is no regulatory oversight of this individual.

**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 sent by email or mail to:

Patient Relations Committee  
College of Physiotherapists of Ontario   
375 University Avenue, Suite 800   
Toronto, Ontario M5G 2J5

[committeesupport@collegept.org](mailto:committeesupport@collegept.org%20)    
  
**Questions?**

**If you have further questions please contact the Deputy Registrar at 1-800-583-5885 ext. 225 or 416-591-3828 extension 225 or email** [committeesupport@collegept.org](mailto:committeesupport@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 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* | | | |