

Funding for Therapy and Counselling for Victims of Sexual Abuse- Application Form

This is a fillable form. Please complete each of the sections below.

Completed application forms can be submitted to the College [via e-mail](#) or regular mail to:

Patient Relations Committee
College of Kinesiologists of Ontario
160 Bloor Street East, Suite 1402
Toronto, ON M4W 1B9

Applicant Contact Information			
First Name			
Last Name			
Street Address		Suite/Apt.	
City/Town			
Province		Postal Code	
Phone Number		Home	Work Mobile
E-mail Address			
Therapist /Counsellor Information (If known)			
First Name			
Last Name			
Street Address		Suite/Apt.	
City/Town			
Province		Postal Code	
Phone Number			

E-mail Address						
Is the therapist/counsellor a regulated health professional (e.g. psychiatrist, psychologist)?	YES		NO		NOT SURE	
If YES, which profession?						
Are the services of this therapist/counsellor eligible for coverage, in whole or in part, by a government or private insurance program?	YES		NO		NOT SURE	
Start date for therapy/counselling services						
This application is for retroactive funding for services received in the past	YES		NO			

Acknowledgement and Consent

I hereby acknowledge and confirm the following:

1. I do not have a family or personal relationship with the therapist/counsellor listed on this application; I do not have any other relationship with the therapist/counsellor that would constitute a potential conflict of interest.
2. I understand that if I choose to see a therapist/counsellor who is not a member of a regulated health profession in Ontario, the therapist/counsellor is not subject to professional oversight or discipline for potential misconduct by a professional regulatory body in Ontario.
 - a. I further understand that this means that if I have concerns regarding the therapist/counsellor, I would not have access to a complaint/disciplinary process through a professional regulatory body, and I would only be able to seek redress for my concerns through private legal action at my own expense.
3. I understand that my application will be reviewed by and my eligibility for funding will be determined by the Patient Relations Committee of the College of Kinesiologists of Ontario.
4. I understand that any funding provided by the College as a result of this application will be paid directly to the therapist/counsellor. I understand that these funds can only be used towards paying for therapy or counselling in relation to sexual misconduct by a kinesiologist and not put towards any other purpose.
5. I understand that the amount of funding provided by the College is subject to a maximum limit set out in legislation and that the amount of funding will be adjusted to reflect other sources of funding from government or private insurance coverage. I acknowledge that the amount of funding provided may be adjusted to reflect reasonable and customary fees for therapy or counselling services.
6. I understand that I am responsible for any charges for therapy/counselling in excess of the amounts covered by the College funding, including any fees for late or cancelled appointments with my therapist/counsellor.
7. I understand that the time period in which funding is available is subject to a five year limit as set out in legislation.
8. I understand that if funding is granted, my therapist/counsellor will be required to submit invoices directly to the College for reimbursement.

Further, I hereby grant consent to the College of Kinesiologists of Ontario to contact the therapist/counsellor listed on this application solely for the purpose of confirming my eligibility and processing my application for funding, as necessary. I acknowledge that this may include verifying the rates charged by my therapist/counsellor and the dates and duration of the services provided.

Applicant Signature

Date