COLLEGE OF KINESIOLOGISTS OF ONTARIO

Funding for Therapy and Counselling for Victims of Sexual Abuse- Therapist/Counsellor Information Form

This form should be completed by the therapist/counsellor and submitted with an application for funding for therapy/counselling for sexual abuse.

Completed information forms can be submitted to the College via email or regular mail to:

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

Therapist/Counsellor Information						
First Name						
Last Name						
Street Address		Suite/Apt.				
City/Town						
Province		Postal Code				
Phone Number						
E-mail Address						
Are you a regulated health professional?	YES	☐	NO	☐		
If YES, which profession?						
Are your services for the patient covered, in whole or in part, by a government or private insurance program?	YES	☐	NO	☐	NOT SURE	☐
Start date for therapy/counselling services						
If therapy/counselling completed, end date						

Patient Information	
First Name	
Last Name	

Declaration

I hereby acknowledge and confirm the following:

1. I do not have a family or personal relationship with the patient listed on this form; I do not have any other relationship with the patient that would constitute a potential conflict of interest.
2. I have never been found guilty of professional misconduct of sexual nature; I have never been found criminally or civilly liable for an act of a sexual nature.
3. I understand that the patient's application for funding will be reviewed by and the eligibility for funding will be determined by the Patient Relations Committee of the College of Kinesiologists of Ontario.
4. I understand that any funds provided by the College can only be used towards paying for therapy or counselling for the patient in relation to an allegation of sexual abuse 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 the time period in which funding is available is subject to a five year limit as set out in legislation; I understand that the funding may be used at the patient's discretion during this time period.
7. I understand that any funding provided by the College as a result of the patient's application will be paid directly to me. In order to receive payment for my services provided to the patient, I agree to submit invoices to the College for reimbursement.
8. I understand that I am responsible for seeking payment from the patient for any amounts for my services not covered by funding supplied by the College. I understand that the funds provided by the College may not be used to cover the costs of late or missed appointments.
9. I understand that the College may verify the dates and times of my appointments with the patient.
10. I agree to keep confidential all information obtained through the application for funding process, including whether funding has been granted, and not to use any such information for an ulterior purpose.

Therapist/Counsellor Signature	Date