College of Opticians of Ontario

(416) 368-3616
(800) 990-9793 (Toll-Free)
(416) 368-2713

FORM A: Application for Funding for Therapy or Counselling

My name is _____

I was sexually abused by _____ (the optician/member) while I was his/her patient. I am asking for funding for therapy and counselling as a result of this sexual abuse.

The abuse started _____(date) and ended _____(date).

Contact Information:

Telephone: _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Therapist/Counsellor Details:

Name of Therapist/Counsellor: _____

Are the services of this therapist/counsellor covered in whole or in part by OHIP or another insurer?

☐ Yes ☐ No ☐ Not Sure

If yes, what is the name of the insurer? _____

By signing this document, I acknowledge and agree to the following:

1. I understand that the Patient Relations Committee of the College of Opticians of Ontario will decide whether I qualify for this funding, and the amount of funding I qualify for.

2. I understand that a decision by the Patient Relations Committee that I am eligible for funding does not constitute a finding of guilt against the above-named optician/member and will not be considered by any other committee of the College dealing with him/her.

3. I understand that if my application is approved all payments will be made directly to my

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therapist/counsellor, and that my therapist/counsellor and I will need to complete and submit a Therapist/Counsellor Information Form (Form B).

4. I understand that there can be no duplicate payment for the same service.

   ☐ I will use any other sources of funding for therapy/counselling that are available to me first. This includes $_____ from _____ (e.g. OHIP or a private insurer).

   OR

   ☐ To my knowledge, neither OHIP nor any other public/private insurer is required to pay for this therapy/counselling. I agree that if at any time OHIP or another public/private insurer becomes required to pay for the therapy/counselling, I will notify the College.

5. I do not have a family relationship with my therapist/counsellor

6. I understand that if my therapist/counsellor is not a member of a regulated health profession, he/she is not subject to professional discipline by the College of Opticians or any other regulatory body.

7. I understand that there will be no payments by the College of Opticians for late or missed appointments.

8. I understand that I must keep confidential all information obtained through the application for funding process, including, if funding is granted, the fact that funding has been granted and the reasons given by the Patient Relations Committee for granting the funding, and to refrain from using that information for any other purpose.

9. I am making this application in good faith and for no improper purpose.

_____ _____

Signature of Applicant Date