CRPO
College of Registered Psychotherapists of Ontario

# Form A: Funding for Therapy and Counselling Application

## APPLICANT INFORMATION

First Name: Last Name:

Address:

City: Province: Postal Code: Country:

Telephone: Email:

## REGISTERED PSYCHOTHERAPIST ABOUT WHOM A COMPLAINT OR REPORT HAS BEEN FILED

### Registered Psychotherapist's Name

First Name: Last Name:

Court/Hearing Date (If applicable):

## NEW THERAPIST/COUNSELLOR INFORMATION

First Name: Last Name:

Address:

City: Province: Postal Code: Country:

Telephone: Email:

Please note: According to section 85.7(7) of the RHPA (Code), the choice of therapist is subject to the following restrictions:

1. The therapist or counsellor must not be a person to whom you have any family relationship.
2. The therapist or counsellor must not be a person who has at any time or in any jurisdictions 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 or counsellor is not a member of a regulated health profession, you understand that the therapist or counsellor is not subject to professional discipline.

### Is this therapist/counsellor a regulated professional?

☐ Yes (if yes, please identify the College of which they are a member.) ☐ No ☐ Don't Know

Name of College:

Are the services of this therapist/counsellor covered by OHIP or another insurer? ☐ Yes ☐ No ☐ Don't Know

Expected or actual start date of counselling:

Signature: Date:

## CONSENT FOR DISCLOSURE OF INFORMATION

I CLIENT NAME: PRINT FIRST NAME, LAST NAME

of STREET ADDRESS, CITY, PROVINCE, POSTAL CODE

hereby authorize: NAME OF NEW THERAPIST/COUNSELLOR WHO IS DISCLOSING INFORMATION

to disclose information, including personal health information, to the College of Registered Psychotherapists of Ontario.

I consent to the following specific information being disclosed: ☐ Appointment Date ☐ Duration ☐ Fee

Signature of Client: Date:

If not client, name: Relationship to Client:

Signature of Witness:

Witness Name: PRINT NAME

## TO BE COMPLETED BY THE APPLICANT

1. I do not have any familial relationship to the therapist or counsellor or any other potential conflict of interest.
2. I understand that if I choose a therapist or a counsellor who is not a regulated professional, the therapist is not subject to professional discipline by CRPO or any other regulatory body.
3. I understand that funding shall be paid only to the therapist or counsellor, and that it shall be used only to pay for therapy or counselling for the sexual abuse that made me eligible for the funding and shall not be applied directly or indirectly for any other purpose.
4. I will use the other sources of funding for therapy or counselling that are available to me first.
5. I understand that there can be no duplicate payment for the same service. To my knowledge, neither OHIP nor any public/private insurer is required to pay for the therapy or counselling I receive from the therapist. If at any time, OHIP or a private insurer becomes required to pay for the therapy or counselling, I shall notify the College.
6. I understand there will be no payment by the College of Registered Psychotherapists of Ontario for late or missed appointments.

Signature of Applicant: Date:

Once you have completed all four pages of this form, please return to the College of Registered Psychotherapists of Ontario via one of the methods listed below:

**Mail:**
Attn: Client Relations Committee
College of Registered Psychotherapists of Ontario
375 University Avenue, Suite 800
Toronto, ON M5G 2J5

**Email:**
clientrelations@crpo.ca

If you have any further questions, please contact clientrelations@crpo.ca