Ontario College of Pharmacists
Putting patients first since 1871

Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Funding Request for Therapy or Counselling

To be completed by the Applicant

I,_____, request access to funding for therapy or counselling under the Patient Relations Program established by the Ontario College of Pharmacists (OCP).

In signing this request, I acknowledge and agree to the following:

1. I understand that I am free to choose a therapist/counsellor that best suits my needs, subject to the following:

    a. I am not in a family relationship with the therapist or counsellor and agree that the term "family relationship" includes any family relationship established through marriage.

    b. The therapist/counsellor must not have been found guilty of professional misconduct of a sexual nature, or been found civilly or criminally liable for an act of a similar nature, or other acts of professional misconduct or incompetence including but not limited to verbal, physical, psychological or emotional abuse, lack of professional boundaries, sexual harassment, and fee/billing improprieties.

    c. I understand that if I choose a therapist/counsellor who is not a regulated health professional, they are not subject to professional discipline by the Ontario College of Pharmacists or any other regulatory body. The College cannot verify whether the therapist/counsellor has ever been found guilty of sexual abuse or has been the subject of a professional/regulatory discipline proceeding.

    d. There should be no conflict of interest between patient and therapist/counsellor.

2. I understand that funding shall be paid directly to the therapist or counsellor.

3. I understand that this funding is for therapy/counselling as it relates to an allegation of sexual abuse by a registrant of the College and shall not be applied directly or indirectly for any other purpose.

4. I understand that the maximum amount of funding available for therapy or counselling is the amount that the Ontario Health Insurance Plan (OHIP) would pay for 200 half-hour sessions (or 100 one hour sessions) of individual out-patient psychotherapy with a psychiatrist. This amount is $17,370.00. I will pay the difference if therapy costs should exceed this amount.

5. I will first use other sources of funding for therapy or counselling that are available to me.

6. I understand that I will pay for any cancellation or late fees billed to me by the therapist/counsellor. These are not covered by the College.

7. I understand that my therapist/counsellor and I will need to complete **Form B**: **Therapist Information**. I understand that College staff will contact me to confirm receipt of the request forms, and will notify me as to whether any additional information is required. Funding payments cannot begin until the forms are fully complete and approved by the College. Therapy/counselling can take place at any time after the incident(s) of sexual abuse is alleged to have occurred.

8. I will advise the College of any changes in therapist/counsellor and I acknowledge that a new **Form B**: **Therapist Information** will need to be completed, reviewed and approved by the College with each new therapist/counsellor.

9. I understand that funding is available for five years from the day on which I first received therapy or counselling in relation to the complaint or report filed with the College.

10. I understand that funding for therapy is an entirely distinct and separate activity and process from the College's complaints and discipline proceedings. Accordingly, receipt of funding for therapy and counselling does not imply nor confirm a finding of professional misconduct for sexual abuse by the registrant.

11. **I understand that there can be no duplicate payment for the same service. To my knowledge the Ontario Health Insurance Plan (OHIP), private insurer or other source of funding, is not covering the costs associated with the therapy or counselling I receive from the therapist/counsellor. If at any time, OHIP or a private insurer can pay for the therapy or counselling, I shall notify the Ontario College of Pharmacists.**

I agree that the contact information provided is correct and that I confirm the statements above. I understand that my agreement is required by the College to process my funding request.

_____

Applicant Signature

_____

Print Name

_____

Date

Contact Information:

Name: _____

Address: _____

City:_____ Province:_____ Postal Code:_____

Please provide below your preferred contact details for exchange of confidential information:

Phone:_____ Email Address: _____

☐ I confirm this email address is secure and private. I authorize the College to use this email for communications that may contain confidential program information.

Please submit forms to:

patientrelations@ocpinfo.com

Patient Relations Program
Ontario College of Pharmacists
483 Huron Street
Toronto, ON M5R 2R4

Questions?

Please direct all questions to patientrelations@ocpinfo.com to ensure a timely response to your inquiries regarding the Patient Relations Program. This account is secure, confidential, and monitored by dedicated staff members at the College.

More information is on our website