Form A: Funding for Therapy and Counselling Application

To be completed by the Applicant

College of Midwives of Ontario | Ordre des sages-femmes de l'Ontario

To be considered for funding, this form must be completed by the applicant. Completed application forms will be reviewed by the Client Relations Committee of the College to determine your eligibility for funding for therapy and counselling. Form B must be completed by your chosen therapist/counsellor.

Applicant Information			
First Name:		Last Name:	
Address:			
City:	Province:	Postal Code:	Country:
Telephone: Fax:		Email:	

Registered Midwife About Whom a Complaint or Report Has Been Filed	
First Name:	Last Name:

Therapist/Counsellor Information			
First Name:		Last Name:	
Address:			
City:	Province:	Postal Code:	Country:
Telephone: Fax:		Email:	

Note: Pursuant to s. 85.7(5) of the RHPA:

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.

Information About Therapy/Counselling:

Is this therapist/counsellor a regulated health professional?

◯ Yes (please provide College name below) ◯ No ◯ Don't Know

Name of College: _____

Are the services of this therapist/counsellor covered by OHIP or another private insurer?

◯ Yes Coverage Amount _____ ◯ No ◯ Don't Know

Expected or actual start date of counselling: _____

Applicant's Consent for Disclosure of Information

I hereby authorize _____ to disclose information,
(Name of Therapist/Counsellor)
including personal health information, to the College of Midwives of Ontario.

I consent to the following information being disclosed:

☐ Appointment Date ☐ Duration ☐ Fee

Signature: _____ Date: _____

Signature of Witness: _____

Witness name: _____

Applicant's Declaration

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 a regulatory body.
3. I am aware of the therapist's or counsellor's training and experience.
4. I understand that funding shall only be paid to the therapist or counsellor and that it shall be used for the sole purpose of paying for therapy or counselling for the sexual abuse that made me eligible for the funding.

5. I understand that the maximum amount of funding payable to any therapist or counsellor is the amount that that the Ontario Health Insurance Plan (OHIP) would pay for 200 half hour sessions of individual out-patient psychotherapy with a psychiatrist.
6. I will use the other sources of funding for therapy or counselling that are available to me first, such as that available through a private insurer.
7. 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 or counsellor. If at any time, OHIP or a private insurer becomes required to pay for the therapy or counselling, I shall notify the College.
8. I understand that the funding available from the College does not cover late appointments, missed appointments or other expenses incidental to receiving therapy, such as travelling costs.
9. I undertake to keep confidential all information obtained through the application funding process, including, if funding is granted, the fact that funding has been granted and any reasons given by the Client Relations Committee for granting the funding, and to refrain from using that information for any other purpose.
10. I understand that a decision by the Client Relations Committee that I am eligible for funding does not constitute a finding of guilt against the above-named midwife and shall not be considered by any other committee of the College dealing with the midwife.

Signature of Applicant: _____ Date: _____

Once you have completed this form, please return to the College of Midwives of Ontario via one of the methods listed below:

Mail:
Attn: Professional Conduct Department
College of Midwives of Ontario
21 St. Clair Avenue East, Suite 303
Toronto, ON M4T 1L9

E-mail:
conduct@cmo.on.ca

If you have any questions, please e-mail conduct@cmo.on.ca or call 416-640-2252 x.224.