

TO: Council

FROM: Patient Relations Committee

DATE: May 28, 2018

SUBJECT: Funding For Therapy and Counselling

PURPOSE:

To provide background information about the legislative amendments to the Funding for Therapy and Counselling Program, and to review draft application materials for the Program.

BACKGROUND:

Under the *Health Professions Procedural Code*, which is Schedule 2 to the *Regulated Health Professions Act*, every College must have a program to provide funding for therapy and counselling to individuals in connection with allegations sexual abuse by members. The program must be administered by the Patient Relations Committee.

On May 30, 2017, Ontario passed Bill 87, the *Protecting Patients Act*, which made a number of significant changes to the Funding for Therapy and Counselling Program. These amendments were proclaimed into force on May 1, 2018, and expand the program significantly.

Previously, a patient only became eligible for funding after the Discipline Committee had made a finding that he or she had been sexually abused by a member. Funding is now available for any person who makes a complaint or is the subject of a report that alleges sexual abuse by a member.

The maximum amount of funding that can be awarded to an applicant has not changed as a result of the amendments, and is the amount that OHIP would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist. Currently, this amounts to \$16,060. Funds must be paid directly to the therapist or counsellor. The maximum period for coverage is five years. Applicants who have been approved for funding may apply to be reimbursed for past therapy costs that were incurred after the alleged abuse took place but before the funding application was made.

Currently, funding may only be used to pay for therapy or counselling, and funds. In the future, additional regulations may be enacted that expand the types of expenses that the funding may cover to things like travel and child care costs.

While the impact of the expanded funding program remains to be seen, it is foreseeable that the expanded eligibility criteria will result in an increased number of applications for funding being made to the College.

FOR CONSIDERATION:

In light of the foregoing, the Patient Relations Committee has determined to develop an application package that includes information and forms for individuals to make an application for funding.

The draft application package is attached, and includes the following:

- Information regarding eligibility criteria and the application process
- Form A: Application for Funding for Therapy or Counselling
- Form B: Therapist Information Form
- Form C: Request for Reimbursement for Past Therapy Costs
- Form D: Therapy Invoice Submission

Once approved, the application package will be made available on the College website.

RECOMMENDATION:

The Patient Relations Committee recommends that the Council approve the attached Funding for Therapy or Counselling Application Package.

ACTION REQUIRED:

Council is asked to decide whether to approve the attached Funding for Therapy or Counselling Application Package.

Funding for therapy and counselling for patients who are alleging sexual abuse or who have been sexually abused by a member of the College of Opticians of Ontario

The College of Opticians of Ontario provides funding for therapy and counselling for patients who have made allegations of sexual abuse by a member.

Who is eligible?

Patients are eligible for funding if it is alleged in a complaint or report to the College that the person was sexually abused by a member while that person was the member's patient.

How much funding is available?

The legislation mandates that the funding cannot exceed a maximum amount of approximately \$16,000. This amount is subject to change. Once a patient is determined to be eligible, the College will let the patient know how much funding he/she will receive. The funding is paid directly to the therapist/counsellor by the College. If some of the cost of the therapy or counselling is covered by OHIP or a private insurer, the payment to the therapist or counsellor is reduced by that amount.

Is there a time limit to apply?

Funding may be provided for up to five years from the date the patient became eligible or the date they first received therapy or counselling. To receive the full benefit of the funding, patients should apply as early as possible.

Can I choose my therapist or counsellor?

If you are eligible for funding you may choose any therapist or counsellor as long as the therapist or counsellor:

- Is not a family member; and
- Has not been found guilty of professional misconduct of a sexual nature or found criminally or civilly liable for a sexual act.

Will my information be kept confidential?

You and your therapist or counsellor must keep all information obtained through the application for funding process confidential. A decision by the Patient Relations Committee that you are eligible for funding does not constitute a finding of professional misconduct against the member and cannot be considered by any other College committee.

If, however, following a separate investigation process, the member is referred to a discipline hearing, disclosure obligations may require that the member receive a copy of the funding application. In addition, if the College wishes to recover costs of therapy from the member, he or she will be notified of your application, and may also be entitled to disclosure of your application or the decision of the Patient Relations Committee.

How do I apply?

To apply, please complete the following forms and submit them to the College:

- **Form A: Application for Funding for Therapy or Counselling**
This form must be completed and signed by the applicant.
- **Form B: Therapist Information Form**
This form must be completed and signed by the therapist or counsellor selected by the Applicant. This form can be submitted together with Form A at the time of the application, or if the Applicant has not yet chosen a therapist or counsellor, it may be submitted after the application has been approved by the Patient Relations Committee.
- **Form C: Request for Reimbursement for Past Therapy Costs**
This form must be completed and signed by an applicant who wishes to request reimbursement for past therapy costs. This form can be submitted together with Form A at the time of the application, or after the application has been approved by the Patient Relations Committee.
- **Form D: Therapy Invoice Submission**
This form must be completed, signed and submitted by the therapist or counsellor with every invoice submitted to the College.

Hard copies of these forms are available on request. Patients can also contact the College for assistance by calling 416-368-3616 or emailing bsloan@coptont.org.

Application forms may be emailed, faxed or mailed to:

Patient Relations Committee
The College of Opticians of Ontario
90 Adelaide St. W., Suite 300
Toronto, ON M5H 3V9
bsloan@coptont.org
Fax: 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

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

FORM B: Therapist/Counsellor Information

Therapist/Counsellor Name: _____

Telephone: _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

1. I am providing/proposing to provide therapy or counselling to _____ (the "Applicant"), who is applying for funding under the program established by the College of Opticians of Ontario (the "College") for persons who have made an allegation of sexual abuse against a member of the College.
2. I do not have a family relationship to the Applicant or any other potential conflict of interest.
3. I understand that funding may only be used to pay for therapy or counselling as determined by the Patient Relations Committee of the College.
4. I understand that the maximum amount of funding payable to any therapist or counsellor approved under this or any other application to the College is the amount that the Ontario Health Insurance Plan would pay for 200 half-hour sessions of individual out-patient psychotherapy with a psychiatrist.
5. My hourly rate for the Applicant is \$_____.
6. I understand that there can be no duplicate payment for the same service.

☐ To my knowledge, neither OHIP nor any other public/private insurer is required to pay for the therapy or counselling I provide/propose to provide to the Applicant. I will notify the College if any other source of funding becomes available to the Applicant.

OR

☐ To my knowledge, some or all of the cost of this therapy or counselling is paid by OHIP or another public/private insurer.

7. ☐ I am a member of the following regulated health profession: College of _____, and my Registration No. is _____.

OR

- ☐ I have never been, or am not currently, a member of a regulated health profession and I have explained to the Applicant that I would not be subject to professional discipline by the College of Opticians of Ontario or any other regulatory body.
8. I have not at any time or in any jurisdiction been found guilty of professional misconduct of a sexual nature.
9. I have never been found liable, criminally or civilly, for an act of a sexual nature.
10. I understand that I must sign and submit a copy of Form D (Therapy Invoice Submission) with each invoice for therapy/counselling that I submit to the College.
11. I understand that there will be no payment by the College for late or missed appointments.
12. 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.
13. By signing this form, I agree that the information I am providing is made in good faith and for no improper purpose

Signature of Therapist/Counsellor

Date

FORM C: Request for Reimbursement for Past Therapy/Counselling Costs

Complete this form if you wish to be reimbursed for past therapy/counselling costs that you paid for out-of-pocket. This request will be reviewed by the Patient Relations Committee of the College of Opticians. In order to be eligible for reimbursement, the following conditions must be met:

- The therapy/counselling occurred after the sexual abuse began;
- The past therapy/counselling costs were paid by you out-of-pocket and you have not been reimbursed for these costs by OHIP or another insurance provider;
- You or your therapist/counsellor have provided copies of invoices or receipts to verify the therapy/counselling costs and dates; and
- Your therapist/counsellor has agreed to reimburse you, and to instead be paid directly by the College [the legislation (the *Health Professions Procedural Code* under the *Regulated Health Professions Act, 1991*) prevents the College of Opticians from paying an applicant directly. If the request for reimbursement for past costs is approved, and if your therapist/counsellor agrees to reimburse you, the College will make arrangements to pay the therapist/counsellor directly].

Applicant's Name: _____

Dates of Therapy: _____

Amount Requested: \$_____

Have you already been reimbursed for this amount by your therapist/counsellor?

☐ Yes ☐ No ☐ Not Sure

Therapist/Counsellor Name: _____

Telephone: _____ Email: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

1. I paid for these therapy/counselling costs out-of-pocket and that I was not reimbursed for these costs by OHIP or any other public/private insurer.

2. I understand that the College may contact my therapist/counsellor to confirm the information in this application and/or to make payment arrangements.
3. I am attaching invoices or receipts for the therapy/counselling costs.
4. This request is made in good faith and for no improper purpose.

Signature of Applicant

Date

FORM D: Therapy Invoice Submission

The therapist/counsellor must sign and submit a copy of this form with each invoice for therapy/counselling provided.

Name of Therapist/Counsellor: _____

I agree that none of the information contained in Form B (Therapist/Counsellor Information) has changed ☐ Yes ☐ No

If any information has changed, please specify:

By signing this form, I agree that the information I am providing is made in good faith and for no improper purpose.

Signature of Therapist/Counsellor

Date