College of Dental Surgeons of Alberta

Suite 402, 7609 109 Street NW
Edmonton, Alberta
T. 780 432 1012
F. 780 433 4864

www.cdsab.ca

FORM A: APPLICATION FOR FUNDING FOR TREATMENT OR COUNSELLING

PATIENT RELATIONS PROGRAM

I am applying for funding for treatment or counselling as a result of sexual misconduct or sexual abuse by an Alberta dentist. I understand that the CDSA will decide whether I am eligible for this funding.

If I qualify, I understand that I will be eligible for a total of $22,500 for the entire period of eligibility. The funds can only be used for my own treatment or counselling and not for any other purpose.

I understand that all payments will be made directly to the therapist/counsellor unless I submit an original receipt that is signed by therapist/counsellor.

Patient's Contact Information:

1. My full name is: _____.
2. The name under which I received dental treatment is: _____.
3. My date of birth is: _____.
4. My phone number is: _____.
5. My email address is: _____.
6. My street address is: _____.
7. I experienced sexual misconduct or sexual abuse by:

   Dr. _____ (the dentist) while I was their patient.
8. The abuse started on _____ and ended on _____.
   DATE DATE
9. I submitted my complaint about Dr. _____ to the CDSA on _____.
10. I am seeking funding for treatment and counselling that (choose one):
    - ☐ started on _____, 20___, after I told the CDSA about the sexual abuse or sexual misconduct
    - ☐ started on _____, 20___, before I told the CDSA about the sexual abuse or sexual misconduct but after the sexual abuse or sexual misconduct started
    - ☐ has not started yet
    - ☐ Other _____
11. My therapist/counsellor for the purposes of the Program are:

    _____

    _____

12. My therapist/counsellor is (choose one):

    □ a regulated health professional, of _____ (College)

    OR

    □ an unregulated health professional, regulated by The Association of Counselling Therapy of Alberta

13. I do not have a familial relationship with my therapist/counsellor. I understand that this means that they are not, in relation to me:

    - a parent or guardian, including a step-parent
    - a spouse or an adult interdependent partner as defined in the *Adult Interdependent*
    - *Relationships Act*
    - a child, including a step-child, grandchild or step-grandchild
    - a grandparent, including a step-grandparent
    - a sibling or step-sibling
    - an extended family member of either me or my spouse or adult interdependent partner, such as an aunt, uncle or cousin

14. I understand that the CDSA will contact my regulated therapist/counsellor or their College to ensure they are in good standing or were in good standing with their College at the time the treatment or counselling was provided to me.

15. I understand that my therapist or counsellor and I will need to complete a Therapist/Applicant Information Form (Form B).

Dated this _____ day of _____, 20____.

_____
Signature of Applicant

_____
Print Name

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FORM B: THERAPIST/COUNSELLOR AND APPLICANT INFORMATION FORM

The Patient Relations Program at the CDSA follows the rules and regulations made into law by the Government of Alberta. This form is to be completed once the Applicant has chosen a therapist/counsellor and is required before funding can be provided by the CDSA.

The therapist/counsellor must complete Part I of the form and the Applicant must complete Part II.

Part I – To be completed by a Regulated health professional therapist/counsellor or an unregulated member of The Association of Counselling Therapy of Alberta

I, _____ (Therapist/Counsellor), am providing or propose to provide treatment and counselling to _____ (the Applicant), who is applying for funding under the Patient Relations Program established by the College of Dental Surgeons of Alberta (CDSA).

I declare that:

1. I am not in a familial relationship with the Applicant which means that I am not their:

    a. parent or guardian, including a step-parent
    b. spouse or an adult interdependent partner as defined in the *Adult Interdependent Relationships Act*
    c. child, including a step-child, grandchild or step-grandchild
    d. grandparent, including a step-grandparent
    e. sibling or step-sibling
    f. extended family member of either the Applicant or the Applicant's spouse or adult interdependent partner, such as an aunt, uncle or cousin

2. I do not know of any conflict of interest or any other potential conflict of interest.
3. I understand that funding provided by the CDSA may only be used to pay for treatment and counselling of the Applicant and to no other person or for any other purpose other than as determined by the CDSA's Patient Relations Program.
4. I understand that the maximum amount of funding payable under this or any other application to the CDSA is the amount of $22,500. Payment for services provided will begin on the day that the CDSA determines that the Applicant is eligible for funding.
5. My hourly rate for this patient is $ _____.
6. To my knowledge, neither the Applicant nor any private insurer is required to pay for the treatment and counselling I propose to or have provided to the Applicant.

7. I am either a Regulated Health Professional or an regulated member of The Association of Counselling Therapy of Alberta (choose one):

    a. Regulated Health Professional:

☐ I became and continue to be a member of the college _____

in _____ (year) and my registration number is _____.

☐ I am in good standing with the college _____.

☐ I ceased to be a member of _____ in _____.
Regulatory Body Year

OR

    b. Unregulated member of The Association of Counselling Therapy of Alberta:

☐ I became and continue to be a member of The Association of Counselling Therapy of Alberta in _____ (year) and my registration number is _____.

☐ I ceased to be a member of The Association of Counselling Therapy of Alberta in _____.
Year

8. To my knowledge, no other sources of funding for the therapy and counselling are available to the Applicant, except the following: _____.
Name of Provider and Amount Available

    If at any time other sources of funding become available to the Applicant, I shall notify the CDSA and, where appropriate, cease submitting claims to the CDSA. I understand that there can be no duplicate payment for the same service.

9. I have never, at any time in any jurisdiction, been found guilty of unprofessional conduct of a sexual nature.

10. I have never been found guilty or liable, criminally or civilly, for an act of a sexual nature.

11. I have attached a copy of my curriculum vitae and a summary of my training and experience, particularly with respect to my ability to provide treatment and counselling to survivors of sexual abuse or sexual misconduct.

12. I will keep confidential all information obtained through the application for funding process, including that funding has been granted and the reasons given by the CDSA. I will refrain from using that information for any collateral or other purpose.

13. I understand there will be no payment by the CDSA for fees related to late or missed appointments and I will not submit invoices for fees related to late or missed appointments.

14. I understand that the Applicant can submit a copy of an original receipt that is signed by me so that they can receive the funding directly from the CDSA.

_____ _____
Signature of the Therapist/Counsellor Date

Part II – To be completed by the Applicant

I, _____, declare I understand the following and it is true and correct:

1. I have read Part I, the information provided by the Therapist/Counsellor.

2. There will be no payment by the CDSA for fees related to late or missed appointments and I will not submit receipts for fees related to late or missed appointments.

3. If at any time other sources of funding become available to me that are used toward this therapy and counselling, I shall notify the CDSA and, where appropriate, cease submitting claims to the CDSA. I understand that there can be no duplicate payment for the same service.

4. I understand that I can submit my original receipt signed by my Therapist/Counsellor to the CDSA and receive funding directly.

5. If applicable - I understand that I have chosen an unregulated member of the Association of Counselling Therapy of Alberta. I understand and accept that this person is not subject to professional discipline.

_____ _____

Signature of the Applicant Date

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FORM C: THERAPY INVOICE SUBMISSION

The Therapist/Counsellor must sign and submit a copy of this form with each original invoice for treatment or counselling provided to the Applicant. The Therapist/Counsellor must include a description and date of the service.

If the Applicant submits an original receipt, the Therapist/Counsellor must sign the receipt and include a description and date of the service that is submitted to the CDSA.

None of the information provided by me in Form B (Therapist/Counsellor and Applicant Information Form) has changed, except for the following:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

Signature of the Therapist/Counsellor Date