NAPA VALLEY COMMUNITY FOUNDATION
FIRST RESPONDER/PUBLIC SAFETY WORKER MENTAL HEALTH PROGRAM

The Napa Valley Community Foundation ("NVCF") **First Responder/Public Safety Worker Mental Health Program** ("Program") has been established to provide First Responders/Public Safety Workers ("Workers") and their families with financial assistance for mental health treatment services when the need for such services arises out of a Worker's employment with a participating agency.

First Responder/Public Safety Workers encounter stressful and traumatic situations, which can affect them as well as their family members. The Program provides funding to pay for mental health treatment for Workers (and/or their spouses/domestic partners or dependent children under age 26, collectively "Eligible Family Members") where such treatment is not covered by insurance (including workers' compensation) or for Workers who pay for their own or an Eligible Family Member's mental health treatment services personally out-of-pocket. The Program will pay up to a maximum of $3,500 per year for a Worker or an Eligible Family Member, with a lifetime cap of $15,000 per household.

Workers eligible for the Program and seeking assistance for themselves or an Eligible Family Member must submit an application directly to NVCF via email on the forms attached. NVCF will contact the mental health professional for the Worker or Eligible Family Member to confirm Worker and/or Eligible Family Member qualification and if an application for the Program Benefits is approved, for relevant billing/payment information.

The Program application process is confidential. Information sufficient to verify the eligibility of the Worker and/or their Eligible Family Members and to permit administration of the Program, including contacting the relevant mental health professional, will be obtained by NVCF. Worker confidential information will not be shared with the employer of a Worker or Worker's Eligible Family Member or any other party without, as applicable, Worker's/Eligible Family Member's express written consent unless required by law or compelled by legal process.

Who is eligible for the Program?	Current full-time Workers both sworn and unsworn, employed by of one of the following agencies: ✓ Napa County Sheriff's Department ✓ Napa City Police Department ✓ Napa City Fire Department The spouse or registered domestic partner of a current, full-time Worker employed by a participating agency; or the dependent children (under age 26 and living with the Worker) of a current, full-time Worker (Eligible Family Members).

What help is available?	When the need for mental health treatment of a Worker or Eligible Family Member arises out of trauma or injury suffered by a Worker carrying out their first responder/public safety duties, the Program will pay for **up to 20 mental health therapy sessions or treatments up to a maximum of $3,500 annually**, with a lifetime cap of $15,000 for Workers and Eligible Family Members. When treatment is for an Eligible Family Member, Worker must certify on the Eligible Family Member Application Supplement that the Worker's household income does not exceed 200% of the Area Median Income ("AMI") for Napa County. (Please see AMI table in Application Supplement for details.) Please note: the lifetime cap of $15,000 is for the Worker's household, including the Worker and any Eligible Family Members. The payments provided by the Program are available when the Worker or Eligible Family Member has exhausted available insurance or the treatment is being paid or provided outside of Workers' Compensation, or the Worker has chosen to pay for treatment outside of insurance coverage.
Will all applications be approved?	The goal of the Program is to support all eligible persons seeking mental health treatment assistance; however, there is not a guarantee that all applications will be approved or that sufficient funds will be available to provide assistance for all applicants.
How do I apply?	To apply for assistance under the Program for the Worker or an Eligible Family Member, the Worker must complete the attached Application for Program Benefits form and the appropriate authorization forms and email them to FRFund@napavalleycf.org. Note: if the application is for an Eligible Family Member, the Worker must ***also*** complete the Eligible Family Member Application Supplement and transmit to the email noted above.
What should I know about confidentiality?	The NVCF application process and the process for making payments to mental health professionals is administered confidentially by NVCF. The Worker and any adult Eligible Family Members will be required to authorize NVCF to receive and use certain private information including private health information in connection with administration of the Program for the purpose of determining eligibility. If seeking benefits for an Eligible Family Member under age 18, the Worker will be required to sign the authorization form on their behalf.

What should I know about confidentiality? (continued)	The Worker's badge or ID number and any other information shared in the application process will be used solely for the purpose of verifying Worker eligibility (and, where relevant, family member eligibility) for the Program and for administration of the Program. The application for and participation in the Program will not be disclosed to the agency for which the Worker works or to any third party without the express written consent of the Worker or adult Eligible Family Member or unless compelled by law. All documents collected in the application process are confidential and will be maintained in confidence by NVCF and used only for purposes of determining eligibility and administering the Program.
Where can I get more information?	For assistance completing the Application documents or to obtain additional information about the Program, contact FRFund@napavalleycf.org.
What forms must be completed for my application?	The following forms must be completed by the Worker and, where noted, by the Worker's Eligible Family Member to apply for Program Benefits:

Required Forms for <u>All</u> Applicants		**Page #**
Application for Program Benefits		Page 4
Certification of Application		Page 5
Authorization by worker for use and disclosure of personal health, financial, and employment information		Page 6
Authorization to release medical information by Mental Health Care provider to NVCF		Page 7-8
Forms for Eligible Family Members (EFMs) *(Required only if applying for Program Benefits for an Eligible Family Member)*	**Applicable To**	**Page #**
Eligible Family Member Application Supplement	All EFMs	Page 10
Authorization by worker for use and disclosure to provider of personal health, financial, and employment information of eligible dependent	EFMs <u>under</u> age 18	Page 11
Authorization by Worker for Release to NVCF of Medical Information by Mental Health Care Provider for Eligible Family Member Under Age 18	EFMs <u>under</u> age 18	Pages 12-13
Eligible Family Member over age 18 authorization for use and disclosure of personal health, financial, and employment information	EFMs <u>over</u> age 18	Page 14
Eligible Family Member over age 18 authorization to release medical information to NVCF by Mental Health Care provider	EFMs <u>over</u> age 18	Pages 15-16

APPLICATION FOR PROGRAM BENEFITS

(To be completed by the First Responder/Public Safety Worker)

I, _____ (Worker Name), request that NVCF provide the benefits under the Napa Valley Community Foundation's First Responder/Public Safety Worker Mental Health Program (the "Program").

I request participation in the Program (check as applicable) for:

☐ Myself ☐ Eligible Family Member

(If you are requesting benefits for an Eligible Family Member, you must complete the attached Eligible Family Member Application Supplement and Consent Forms for yourself and for dependents under age 18. If the eligible dependent for whom Program Benefits are sought is over age 18 that person must complete the attached Adult Dependent Consent Forms.)

I am employed by _____ (agency name).

My badge number or agency ID number is: _____.

Name and contact information of the **Mental Health Treatment provider** for Worker or Eligible Family Member:

Provider Name: _____

Provider Phone Number: _____

Provider Email Address:_____

CERTIFICATION OF APPLICATION

I hereby certify by signing this Application that I (or as applicable, my Eligible Family Member as set forth on page 1 hereof) meet the eligibility requirements for the Program.

I further certify that the information provided in this Application and any attachments to it are true and correct as of the date set forth below. My signature authorizes Napa Valley Community Foundation (NVCF) to verify all the information I have provided in or with this Application and any attachments thereto, so that it may consider my Application and for purposes of administration of my or my Eligible Family Member's participation in the Program.

I agree that any intentional misrepresentation of or material omission from information contained in my Application or any attachments to it will result in forfeiting my Application and exclusion from future benefits from the Program.

I understand that I am not legally entitled to receive a grant, reimbursement or other funds from the Program, and that the decision on any such disbursement is at the complete and sole discretion of NVCF. In this regard, I acknowledge that NVCF shall not be liable to me for, and I hereby release it from, any costs, expenses, damages, claims or losses incurred by me in connection with the approval or disapproval of my Application, or for anything NVCF may do or refrain from doing in good faith.

_____ _____

Signature Date

_____

Print Name

WHERE TO SEND COMPLETED DOCUMENTS

Completed application documents must be submitted to
FRFund@napavalleycf.org

AUTHORIZATION BY WORKER FOR USE AND DISCLOSURE OF PERSONAL HEALTH, FINANCIAL, AND EMPLOYMENT INFORMATION

I authorize the use of my personal health information, financial, and employment information contained in my Application to NVCF and as may be provided to NVCF, solely for the purpose of NVCF's determination of my eligibility for the Program and/or that of my Eligible Family Member and for purposes of administration of my participation in the Program or that of my Eligible Family Member. I further authorize NVCF to use or disclose my personal health information or that of my eligible dependent under age 18 in connection with future requests for payment of benefits under the Program, determination of eligibility to participate in the Program, billing information, number and frequency of treatments and the dollar amount of treatment received that is not paid by insurance or is paid by me out of my own pocket.

I understand that this authorization will expire one year from the date I sign it.

I understand that I have the right to refuse to sign this Authorization. However, my refusal to sign this authorization may affect my ability to receive benefits under the Program.

I understand that I may revoke this Authorization at any time by notifying NVCF in writing, except that revocation of this authorization will not apply to information that has already been released before the revocation is received. To do so I understand that I must submit any revocation in writing to FRFund@napavalleycf.org.

I am signing this Authorization voluntarily. Neither NVCF nor any other person or entity nor my Mental Health Care provider is authorized to disclose my health information or that of my eligible dependent contained in my Application or obtained in connection with administration of the Program except with my written approval or as otherwise required by law.

_____ _____

Signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION BY MENTAL HEALTH CARE PROVIDER TO NVCF

Worker/ Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize

_____

(name of Mental Health Care Provider(s)) (collectively the "Provider") to disclose those portions of my medical record necessary to determine my eligibility for the Program, including the number of sessions I've had with the Provider in the last 12 months, how such sessions have been paid for (i.e., via insurance, EBP or out-of-pocket), and whether, in the opinion of the Provider, I would benefit from additional sessions paid for by the Program, to Napa Valley Community Foundation. By signing where indicated below, I acknowledge:

- This Authorization will expire one (1) year after the date of signature on this form or upon Provider's receipt of my written revocation. It is my responsibility to inform Provider of any desired change to this Authorization.
- I understand that I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
- I understand that any cancellation or modification of this Authorization must be in writing.
- I understand that I have the right to revoke this Authorization at any time, except that revocation of this Authorization will not apply to information that has already been released before the revocation is received.
- I have the right to refuse to sign this Authorization. Provider will not condition my treatment, payment, enrollment, or eligibility for benefits, as applicable, on whether I sign this Authorization, provided that I may not be able to participate in the First Responder/Public Safety Worker Mental Health Program if my eligibility cannot be appropriately determined.

- The information being disclosed may be protected by federal and state confidentiality rules. Once the information is disclosed as authorized above, that information may be re-disclosed by the recipient of the information and such re-disclosure may no longer be protected by federal or state privacy laws.
- I agree to waive all claims against Provider for the release of the information authorized to be disclosed.

I have read and understand the terms of this Authorization. By my signature below, I hereby knowingly and voluntarily authorize the use and disclosure of the information for the purposes described above.

_____ _____

Signature of Worker (or Legal Representative) Date

_____

If applicable: Legal Representative's Name and Relationship to Patient

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I_____ hereby **refuse** to release confidential information regarding my treatment by the *Provider*. I understand that the purpose of sharing information is to help me be considered for support from the First Responder/Public Safety Worker Mental Health Program. I understand that my refusal to share information does not affect my insurance coverage but may prevent me from participating in the Program.

_____ _____

Signature of Worker (or Legal Representative) Date

WHERE TO SEND COMPLETED DOCUMENTS

Completed application documents must be submitted to
FRFund@napavalleycf.org

THE FOLLOWING PAGES CONTAIN SUPPLEMENTAL DOCUMENTATION REQUIRED ONLY IF APPLYING FOR PROGRAM BENEFITS FOR ELIGIBLE FAMILY MEMBERS.

PLEASE REVIEW AND COMPLETE THESE FORMS AS APPLICABLE.

ELIGIBLE FAMILY MEMBER APPLICATION SUPPLEMENT

- I request that the Program Benefits provided by NVCF for Eligible Family Members be provided to _____ (Eligible Family Member)

- My relationship to the above Eligible Family Member is:
  - ☐ spouse
  - ☐ domestic partner
  - ☐ dependent child over age 18
  - ☐ dependent child under age 18

ELIGIBLE FAMILY MEMBER WORKSHEET

In order to provide benefits to Eligible Family Members under the Program, NVCF must assess the financial situation of your household. We recognize that what we are asking you is deeply personal and will never disclose what you share in this Worksheet with any other party.

Program participation for a spouse/registered domestic partner or dependent child under age 26 is limited to Workers whose household income is at or below 200% of Napa County Area Median Income (AMI), based on family size, per the table below.

	Household Size					
	1	2	3	4	5	6
AMI ^	$90,700	$103,700	$116,650	$129,600	$139,950	$150,350
200% of AMI	$181,400	$207,400	$233,300	$259,200	$279,900	$300,700

^ Area Median Income for Napa County, 2024. See link below for source.
https://www.cityofnapa.org/DocumentCenter/View/9897/2024-Affordable-Rents-and-Income-Limits-Carts?bidId=

What was your total household income last year? Please enter the amount shown on last year's IRS Form 1040, line 8(b), Adjusted Gross Income: $ _____

Please tell us about your household by filling in the table below.

Name(s) of other people in your household	Relationship to you (for example: child, spouse, roommate, other family)	Age	Occupation

AUTHORIZATION BY WORKER FOR USE AND DISCLOSURE TO PROVIDER OF PERSONAL HEALTH, FINANCIAL, AND EMPLOYMENT INFORMATION OF ELIGIBLE FAMILY MEMBER UNDER AGE 18

I am authorized to grant authorization to NVCF on behalf of _____, my dependent child under age 18 ("Dependent").

I authorize the use of the personal health, financial, and employment information of Dependent contained in my Application to NVCF and as may be provided to NVCF, solely for the purpose of NVCF's determination of eligibility for the Program and for purposes of administration of my participation in the Program and/or that of my Dependent. I further authorize NVCF to use or disclose my personal health information or that of my Dependent in connection with future requests for payment of benefits under the Program, determination of eligibility to participate in the Program, billing information, number and frequency of treatments and the dollar amount of treatment received that is not paid by insurance or is paid by me out of my own pocket.

I understand that this authorization will expire one year from the date I sign it. I understand that I have the right to refuse to sign this Authorization. However, my refusal to sign this authorization may affect my ability and/or my Dependent's ability to receive benefits under the Program.

I understand that I may revoke this Authorization at any time by notifying NVCF in writing, except that revocation of this authorization will not apply to information that has already been released before the revocation is received. To do so I understand that I must submit any revocation in writing to FRFund@napavalleycf.org.

I am signing this authorization voluntarily. Neither NVCF nor any other person or entity nor my Mental Health Care provider is authorized to disclose my health information or that of my eligible dependent contained in my application or obtained in connection with administration of the Program except with my written approval or as otherwise required by law.

I hereby sign this authorization on behalf of _____ (name of Dependent).

_____ _____

Signature Date

_____

Print Name

AUTHORIZATION TO RELEASE MEDICAL INFORMATION OF ELIGIBLE FAMILY MEMBER UNDER AGE 18 TO NVCF BY MENTAL HEALTH CARE PROVIDER

Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize

_____

(name of Mental Health Care Provider(s)) (collectively the "Provider") to disclose those portions of _____ (Dependent under 18, "Dependent")'s medical record necessary to determine eligibility for the Program, including the number of sessions Dependent has had with the Provider in the last 12 months, how such sessions have been paid for (i.e., via insurance, EBP or out-of-pocket), and whether, in the opinion of the Provider, Dependent would benefit from additional sessions paid for by the Program, to Napa Valley Community Foundation. By signing where indicated below, I acknowledge:

- This Authorization will expire one (1) year after the date of signature on this form or upon Provider's receipt of my written revocation. It is my responsibility to inform Provider of any desired change to this Authorization.
- I understand that I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original. I understand that any cancellation or modification of this Authorization must be in writing. I understand that I have the right to revoke this Authorization at any time, except that revocation of this Authorization will not apply to information that has already been released before the revocation is received.
- I have the right to refuse to sign this Authorization. Provider will not condition Dependent's treatment, payment, enrollment, or eligibility for benefits, as applicable, on whether I sign this Authorization, provided that Dependent may not be able to participate in the First Responder/Public Safety Worker Mental Health Program if his/her eligibility cannot be appropriately determined.

- The information being disclosed may be protected by federal and state confidentiality rules. Once the information is disclosed as authorized above, that information may be re-disclosed by the recipient of the information and such re-disclosure may no longer be protected by federal or state privacy laws.
- I agree to waive all claims against Provider for the release of the information authorized to be disclosed.

I am authorized to make this authorization on behalf of my Dependent identified above. I have read and understand the terms of this Authorization. By my signature below, I hereby knowingly and voluntarily authorize the use and disclosure of the information for the purposes described above.

_____ _____

Signature of Worker (or Legal Representative) Date

_____

If applicable: Legal Representative's Name and Relationship to Patient

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I_____ hereby **refuse** to release confidential information regarding Dependent's treatment by the *Provider*. I understand that the purpose of sharing information is to help Dependent be considered for support from the First Responder/Public Safety Worker Mental Health Program. I understand that my refusal to share information does not affect Dependent's insurance coverage but may prevent Dependent from participating in the Program.

_____ _____

Signature of Worker (or Legal Representative) Date

WHERE TO SEND COMPLETED DOCUMENTS
Completed application documents must be submitted to
FRFund@napavalleycf.org

ELIGIBLE FAMILY MEMBER OVER AGE 18 AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH, FINANCIAL, AND EMPLOYMENT INFORMATION

I sign this Authorization in connection with the application of the Worker in relation to whom I am a Dependent for benefits under the NVCF Program.

I authorize the use of my personal health, financial, and employment information contained in the Application to NVCF and as may be provided to NVCF, solely for the purpose of NVCF's determination of my eligibility for the Program and for purposes of administration of my participation in the Program. I further authorize NVCF to use or disclose my personal health information in connection with future requests for payment of benefits under the Program, determination of eligibility to participate in the Program, billing information, number and frequency of treatments and the dollar amount of treatment received that is not paid by insurance or is paid by the Worker in relation to whom I am a Dependent out of their own pocket.

I understand that this authorization will expire one year from the date I sign it.

I understand that I have the right to refuse to sign this Authorization. However, my refusal to sign this authorization may affect my ability to receive benefits under the Program.

I understand that I may revoke this Authorization at any time by notifying NVCF in writing, except that revocation of this authorization will not apply to information that has already been released before the revocation is received. To do so I understand that I must submit any revocation in writing to FRFund@napavalleycf.org.

I am signing this authorization voluntarily. Neither NVCF nor any other person or entity nor my Mental Health Care provider is authorized to disclose my health information contained in my application or obtained in connection with administration of the Program except with my written approval or as otherwise required by law.

_____ _____

Signature of Eligible Family Member Date

_____

Print Name

ELIGIBLE FAMILY MEMBER OVER AGE 18 AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO NVCF BY MENTAL HEALTH CARE PROVIDER

Patient Name: _____ Date of Birth: _____

I, _____, hereby authorize

_____

(name of Mental Health Care Providers) (collectively the "Provider") to disclose those portions of my medical record necessary to determine my eligibility for the Program, including the number of sessions I've had with the Provider in the last 12 months, how such sessions have been paid for (i.e., via insurance, EBP or out-of-pocket), and whether, in the opinion of the Provider, I would benefit from additional sessions paid for by the Program, to Napa Valley Community Foundation. By signing where indicated below, I acknowledge:

- This Authorization will expire one (1) year after the date of signature on this form or upon Provider's receipt of my written revocation. It is my responsibility to inform Provider of any desired change to this Authorization.
- I understand that I have a right to receive a copy of this Authorization. A copy of this Authorization is as valid as the original.
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- I understand that I have the right to revoke this Authorization at any time, except that revocation of this Authorization will not apply to information that has already been released before the revocation is received.
- I have the right to refuse to sign this Authorization. Provider will not condition my treatment, payment, enrollment, or eligibility for benefits, as applicable, on whether I sign this Authorization, provided that I may not be able to participate in the First Responder/Public Safety Worker Mental Health Program if my eligibility cannot be appropriately determined.
- The information being disclosed may be protected by federal and state confidentiality rules. Once the information is disclosed as authorized above, that information may be re-disclosed by the recipient of the information and

such re-disclosure may no longer be protected by federal or state privacy laws.

- I agree to waive all claims against Provider for the release of the information authorized to be disclosed.

I have read and understand the terms of this Authorization. By my signature below, I hereby knowingly and voluntarily authorize the use and disclosure of the information for the purposes described above.

_____ _____
Signature of Eligible Family Member Date

_____
Print Name

I _____ hereby **refuse** to release confidential information regarding my treatment by the *Provider*. I understand that the purpose of sharing information is to help me be considered for support from the First Responder/Public Safety Worker Mental Health Program. I understand that my refusal to share information does not affect my insurance coverage but may prevent me from participating in the Program.

_____ _____
Signature of Eligible Family Member Date

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FRFund@napavalleycf.org