

## 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 one of the following agencies:

- ✓ American Canyon Fire Protection District
- ✓ Calistoga Police Department/Calistoga Fire Department
- ✓ Napa City Police Department/Napa City Fire Department\*
- ✓ Napa County District Attorney's Office
- ✓ Napa County Sheriff's Department
- ✓ St. Helena Police Department/St. Helena 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).

\* Effective 9/1/2025, Napa Police and Fire Workers and their spouses may seek assistance directly from Restoration First Responder Network (RFRN) and do not need to complete an application. Please see <a href="RFRN">RFRN</a> website for additional information or call (707) 330-7904. However, if applying for assistance on behalf of a dependent child (under age 26 and living with the Worker), this application is still required.

### 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 therapy sessions up to \$175 per hour, up to a maximum of \$3,500 per year (20 hours) for a Worker or an Eligible Family Member, with a lifetime cap of \$15,000 per household.

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.

Effective 9/1/2025, Napa Police and Fire Workers and their spouses may seek assistance directly from Restoration First Responders Network (RFRN). Please see <a href="RFRN website">RFRN website</a> for additional information.

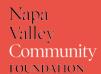
Will all applications be approved?	The goal of the Program is to support all eligible persons seeking mental health treatment assistance; however, there is not a guarantee that all applications will be approved or that sufficient funds will be available to provide assistance for all applicants.
How do 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 <a href="mailto:FRFund@napavalleycf.org">FRFund@napavalleycf.org</a> .
	Note: if the application is for an Eligible Family Member, the Worker must <u>also</u> 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 <a href="mailto:FRFund@napavalleycf.org">FRFund@napavalleycf.org</a> .



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:

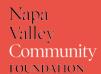
, approximation		
Required Forms for <u>All</u> Applicants		
Application for Program Benefits		Page 4
Certification of Application		Page 5
Authorization by worker for use and disclosure of personal health, and employment information	financial,	Page 6
Authorization to release medical information by Mental Health Car to NVCF	e provider	Pages 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)

provide the be	enefits under the Napa Valley C Mental Health Program (the "P	ommunity Foundation's First Responder/Public		
I request part	icipation in the Program (check	as applicable) for:		
☐ Myself	☐ Eligible Family Member	☐ Myself <u>and</u> Spouse/Registered domestic partner (Couples Therapy)		
(If you are requesting benefits for an Eligible Family Member, or for Couples Therapy, you must complete the attached Eligible Family Member—Under Age 18 Application Supplement and Consent Forms for yourself and for dependents under age 18. If the Eligible Family Member for whom Program Benefits are sought is over age 18, that person must complete the attached Eligible Family Member—Over Age 18 Consent Forms.				
	uesting <b>Couples Therapy</b> , your s applicable Eligible Family Meml	spouse or registered domestic partner must also ber forms.)		
I am employed	d by	(agency name).		
My badge num	nber or agency ID number is:	·		
Name and con Eligible Family		Health Treatment provider for Worker or		
Provider Name	e:			
Provider Phon	e Number:			
Provider Emai	l 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



## 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.

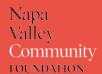
I understand that this authorization will expire one year from the date I sign it.

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

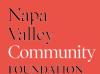
Worker/ Patient Name:	Date of Birth:
Name	
ı,	, hereby authorize
disclose those portions of my eligibility for the Program, incl	Provider(s)) (collectively the "Provider") to medical record necessary to determine my uding the number of sessions I've had with the
•	how such sessions have been paid for (i.e., via t), and whether, in the opinion of the Provider,

o 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 would benefit from additional sessions paid for by the Program, to Napa Valley

Community Foundation. By signing where indicated below, I acknowledge:

- 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.
- o 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.

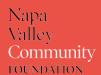


- The information being disclosed may be protected by federal and state confidentiality rules. Once the information is disclosed as authorized above, that information may be re-disclosed by the recipient of the information and such re-disclosure may no longer be protected by federal or state privacy 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 R	 Relationship to Patient
I hereby <b>refuse</b> to relargarding my treatment by the <i>Provider</i> . I undesharing information is to help me be considered Responder/Public Safety Worker Mental Health Forefusal to share information does not affect my prevent me from participating in the Program.	ed for support from the First Program. I understand that my
Signature of Worker (or Legal Representative)	Date

#### WHERE TO SEND COMPLETED DOCUMENTS



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.



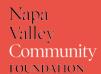
#### **ELIGIBLE FAMILY MEMBER APPLICATION SUPPLEMENT**

•	•	·	provided by N Iligible Family	IVCF for Eligib / Member)	ole Family Me	embers be
<ul> <li>My relationship to the above Eligible Family Member is:         □ spouse         □ dependent child <u>over</u> age 18         □ dependent child <u>under</u> age 18</li> </ul>				_		
	ELI	GIBLE FAM	ILY MEMBEI	R WORKSHE	ET	
In order to prov the financial si personal and w	tuation of yo	our household	I. We recogniz	ze that what v	we are asking	you is deeply
Program partic 26 is limited to Median Income	Workers w	hose househo	old income is	at or below	•	_
			Housel	nold 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		(for example	ship to you e: child, spouse, 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 dependent child under age 18 ("Depende	
Dependent contained in my Application solely for the purpose of NVCF's determ purposes of administration of my participation. I further authorize NVCF to uor that of my Dependent in connection under the Program, determination of elimeters.	th, financial, and employment information of to NVCF and as may be provided to NVCF, ination of eligibility for the Program and for cipation in the Program and/or that of my se or disclose my personal health information with future requests for payment of benefits gibility to participate in the Program, billing eatments and the dollar amount of treatment is paid by me out of my own pocket.
understand that I have the right to refu	l expire one year from the date I sign it. I use to sign this Authorization. However, my ect my ability and/or my Dependent's ability
writing, except that revocation of this au	chorization at any time by notifying NVCF in thorization will not apply to information that evocation is received. To do so I understand ing to <a href="mailto:FRFund@napavalleycf.org">FRFund@napavalleycf.org</a> .
nor my Mental Health Care provider is au that of my eligible dependent contained	thorized to disclose my health information or in my application or obtained in connection option with my written approval or as otherwise
I hereby sign this authorization on beha Dependent).	alf of (name of
Signature	Date
Print Name	



## AUTHORIZATION TO RELEASE MEDICAL INFORMATION OF ELIGIBLE FAMILY MEMBER — <u>UNDER AGE 18</u> TO NVCF BY MENTAL HEALTH CARE PROVIDER

Patient Date of Name: Birth:		
l,	, hereby authorize	
(name of Mental Health Care Pro	ovider(s)) (collectively the "Provider") to disclose	
those portions of	(Dependent under 18,	
"Dependent")'s medical reco	rd 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, Dependen		
would benefit from additional	sessions paid for by the Program, to Napa Valley	
	ning 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.
- O 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.

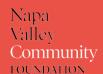


- The information being disclosed may be protected by federal and state confidentiality rules. Once the information is disclosed as authorized above, that information may be re-disclosed by the recipient of the information and such re-disclosure may no longer be protected by federal or state privacy 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
I hereby <b>refuse</b> to regarding Dependent's treatment by the Propurpose of sharing information is to help Deperfrom the First Responder/Public Safety Wor understand that my refusal to share information insurance coverage but may prevent Dependence Program.	ndent be considered for support ker Mental Health Program. I on does not affect Dependent's
Signature of Worker (or Legal Representative)	Date

#### WHERE TO SEND COMPLETED DOCUMENTS



## ELIGIBLE FAMILY MEMBER — <u>OVER AGE 18</u> 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 an Eligible Family Member 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 an Eligible Family Member out of their own pocket.

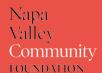
I understand that this authorization will expire one year from the date I sign it.

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		

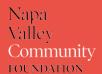


## ELIGIBLE FAMILY MEMBER — OVER AGE 18 AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO NVCF BY MENTAL HEALTH CARE PROVIDER

Patient Name:	Date of Birth:	
l,	, 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.
- 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

of the information for the purposes described above.			
Signature of Eligible Family Member	Date		
Print Name			
I hereby <b>refuse</b> to regarding my treatment by the <i>Provider</i> . sharing information is to help me be constructed Responder/Public Safety Worker Mental Hear refusal to share information does not affect prevent me from participating in the Program	idered for support from the First Ilth Program. I understand that my It my insurance coverage but may		
Signature of Eligible Family Member	 Date		

#### WHERE TO SEND COMPLETED DOCUMENTS