Sarah's

A Bereavement Camp for Kids

Everyone grieves differently, and kids are no exception. The annual Sarah's Heart Bereavement Camp for Kids is a one-day, fun-filled camp that offers grief education and support. It is designed for children ages 6 to 12 who have experienced the death of a significant person in their life – a parent, sibling, grandparent, or other close family member – within the last two years.

Each camper has the opportunity to remember their loved one, while also enjoying traditional camp experiences. This camp event is staffed by certified/licensed professionals and volunteers of Heritage Hospice, Inc.

When: Friday June 6, 2025, from 8:30 a.m. to 4:30 p.m.

Where: Camp Horsin' Around
1159 Claunch Road
Perryville, KY

Cost: No fees to attend. But there will be a few items you'll bring with you!

Registration Deadline: May 23, 2025

For mor information: Call Ashley Arnold, LCSW, ACHP-SW, at 859-236-2425 or 1-800-203-633, or email to aarnold@heritagehospice.com

Heritage Hospice Inc.
Caring for Generations

June 6, 2025

Camper Application Packet

Heritage Hospice, Inc.

REGISTRATION FORMS

Return registration forms to:

Ashley Arnold, LCSW, ACHP-SW
Heritage Hospice, Inc.
P.O. Box 1213
120 Enterprise Drive
Danville, KY 40423

There is no fee to attend camp!

Spaces are limited, an acceptance is FIRST COME, FIRST SERVE!

DEADLINE FOR APPLICATION IS May 23, 2025

Questions? Call 859-236-2425 or email aarnold@heritagehospice.com

Attendee Consent Form

Attendee Name: _____ Date of Birth: _____ Gender: M/F

Parent or Guardian if Attendee is a minor child: _____

Address: _____

Phone: _____ Email: _____

Add'l Emergency Contact: _____ Phone: _____

Please list all known medical conditions, medications, and allergies on the following page.

Consent for Activities for Minor Child

I do_____ I do not _____ agree that my child is authorized to participate in any and all officially administered, sponsored or sanctioned activities conducted by _____ ("Camper Organization") at the property located at 1159 Claunch Road, Perryville, Kentucky owned by Horsin' Around Camp, Inc., a Kentucky nonprofit corporation ("Camp Horsin' Around"). Such activities may include, but are not limited to, basketball, wall climbing, swimming, boating, fishing, archery, low ropes course, Gaga ball, disc golf, hiking, wading, field games, and yard games. Pleas list any activities the minor child should NOT participate in: _____
_____

Consent to Treat for Minors and Adults

I do_____ I do not _____ authorize emergency first aid care, to include the administration of medications listed in this form, may be administered by trained personnel to my minor child/self while at Camp Horsin' Around.

Consent to Media Use for Minors and Adults

I do_____ I do not _____ Camper Organization and Camp Horsin' Around the absolute right and permission to publish and or reproduce any photograph or video of my minor child/self in which my minor child/self may be included in whole or in part for any lawful purpose whatsoever.

_____

Signature (Self or Parent/Guardian) **Date**

_____

Printed Name

Known Medical conditions: _____

_____

Please list information for all medication the participant will be taking while at camp:

Name of Medication	Dose	Rout (e.g. oral, IM, IV, SQ, other)	Frequency	Reaction information

Current Treatments (therapies, dialysis, etc.): _____

_____

Dates and type of last chemotherapy (if relevant): _____

Please list information for all allergens the participant may react to while at camp:

Allergen: Food, medications, animals, plants, products, etc.	Reaction to exposure	Treatment required	Accommodation Needed

Has the participant ever had an allergic reaction to an insect bite/bee sting? Yes ___ No ___

(If yes, please describe.) _____

_____

Pleas share any additional information that you think would be helpful: _____

_____

_____

120 Enterprise Dr.
Danville, KY 40422
859-236-2425

AUTHORIZATION FOR TREATMENT OF A MINOR

Printed Client Name: _____

Birth Date: _____

Parent/Legal Guardian: _____

Copy of Guardianship Attached: _____ Yes _____ No

Mailing Address: _____

Street Address: _____

City, State, Zip: _____

Phone: (H) _____ (C)_____
(W) _____

I, the undersigned, hereby authorize the Clinical Counseling Services as a representative of ***Heritage Hospice, Inc.*** to provide counseling to the above-named minor child at school or in a designated location outside of the home setting after school.

_____ I have received a copy of Heritage Hospice, Inc. Notice of Hospice Privacy
(Initial) Practices/HIPPA.

_____ _____
Parent/Legal Guardian **Date**

_____ _____
Witness **Date**

_____ Copy of Guardianship Document Received
(HHI Initial)

HHI
Dev. 12/00
Reviewed:
Revised: 9/08, 2/11, 2/13, 5/24

Community Client Bereavement Consent for Services

Date: _____

Client Name: _____

Date of Birth:_____Social Security Number: _____

Email: _____

Home Phone Number:_____Cell Phone Number: _____

Work Phone Number:_____Work Status: _____

Address:_____City:_____Zip: _____

Referred by: _____

Emergency Contact Name:_____Relationship:_____

Emergency Contact Phone Number: _____

* I,_____, hereby consent to community bereavement services provided by Heritage Hospice, Inc.

_____I have received a copy of Heritage Hospice, Inc.'s Notice of Hospice Privacy Practices/HIPAA.
(initial)

*Client Signature:_____Date: _____

D-POA/Guardian Signature:_____Date: _____
_____copy of D-POA received _____copy of Guardianship document received

Staff/Witness Signature:_____Date: _____

*If the client is under age 18, parent/guardian must also complete and sign the Authorization for Treatment of Minor form.

HERITAGE HOSPICE, INC.

CONSENT FOR
PATIENT STATUS PHOTO

I,_____, give permission to have a photo taken of (name/self)_____for the purpose of recording overall patient status at this time.

I understand that I may revoke this authorization at any time. I also understand that any revocation of this authorization must be in writing. To obtain a copy of an authorization revocation form, I may contact the Director of Clinical Services, Heritage Hospice, Inc., at P.O. Box 1213, Danville, KY 40423, or by calling 859.236.2425 or 800.203.66333.

_____ _____

Patient Signature **Date**

_____ _____

Representative Signature (if patient unable) **Date**

_____ _____

Hospice Representative **Date**

HHI
Dev: 6/04
Reviewed: 1/21, 5/22, 5/24
Revised: 11/08, 2/2020

Transportation Authorization Form

I(parent/guardian) _____give the following person/people permission to pick up (child's name) _____.

Name	Driver's License #
1. _____	_____
2. _____	_____
3. _____	_____

_____ _____

Parent Signature Date

I (parent/guardian)_____give Heritage Hospice, Inc. permission to transport my child (child's name) _____to and from camp.

_____ _____

Parent Signature Date

HHI
Dev. 5/14
Rev.

HERITAGE HOSPICE, INC.

RELEASE OF ELECTRONIC IMAGE/INFORMATION

I,_____, give my permission for **Heritage Hospice, Inc.** to use my photo or any form of my electronic image for any of the purposes I have listed below.

In addition, I give my permission for any remarks or comments I make as a result of an interview with_____of **Heritage Hospice, Inc**. to be published for any of the purposes I have checked below.

_____Public Education Events
_____Newspaper Articles/Advertisements
_____Agency Newsletters
_____Agency Brochures
_____Special Event Flyers/Materials
_____Website Design/Materials
_____Agency Social Media outlets, including but not limited to, Facebook, Instagram, Twitter, etc.

This release is effective until revoked in writing by the undersigned. Such revocation shall only be effective to prevent any expanded future use of the records. The facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I have read and understand the above:

I understand that I may revoke this authorization from Heritage Hospice, Inc. printed and/or electronic information at any time. I also understand that any revocation of this authorization must be made in writing. To obtain a copy of an authorization revocation form, I may contact the Director of Clinical Services at Heritage Hospice, Inc., Post Office Box 1213, Danville, Kentucky 40423, or by calling 859.236.2425 or 1.800.203.6633.

_____ _____
Signature **Date**

Contact Phone Number: _____

Contact Email: _____

_____ _____
Heritage Hospice, Inc. Representative **Date**

Dev: 9/03
Reviewed: 8/13, 11/15, 1/21, 5/22, 5/24
Revised: 3/06, 9/08, 1/10 1/11, 8/13, 5/19

Heritage Hospice Inc.
Caring for Generations

SARAH'S HEART CAMP

HEALTH HISTORY FORM

Child's Name

_____

Last First Middle

Home Address –

_____

_____

City _____ State _____ Zip

Date of Birth _____ Age_____ Male ☐ Female ☐

Mother's/Guardian's Name

_____

Day Phone _____ Evening Phone_____

Father's/Guardian's Name

_____

Day Phone _____ Evening Phone _____

In case of an emergency and parent/guardian cannot be reached, contact:

Name

_____

Day Phone _____ Evening Phone _____

Name

_____

Day Phone _____ Evening Phone _____

HEALTH HISTORY (check those that apply)

__Asthma	__Nose Bleeds	__Heart Disease
__Convulsions/seizures	__Special Dietary needs	__Wears contact lenses
__Diabetes	__Ear Infections	__Allergies to:
__Emotional Problems	__Epilepsy	__Food
__Fainting	__Hearing Impairment	__Animals

__Other _____ _Medicines

Please explain any "checked" answers from the last question. Indicate any information useful to the adult in charge in relation to any of the health conditions. Also indicate any activities to be encouraged or restricted.

_____
_____
_____
_____
_____
_____
_____

MEDICATIONS:

Please list current medications prescribed for your child to take while at **SARAH'S HEART CAMP** and the purpose of each.

	Name of Medication	**Purpose**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

List date of child's last Tetanus Injection: _____

I give permission to the camp nurse to administer prescriptions, over the counter medications, first aid and/or access to medical treatment if needed to/for my child.

_____ _____

Signature of Parent/Guardian Date

The hospital closest to camp requires a patient's social security number. If you wish to provide it, this information will only be released in the event of a hospital visit. Social Security # _____

Heritage Hospice Inc.
Caring for Generations

MINOR CHILD/ADOLESCENT BEREAVEMENT HISTORY

Please help us to understand your child's loss experience by providing answers to the following questions**.**

1. PERSONAL INFORMATION ABOUT YOUR CHILD/ADOLESCENT

Name:_____ Nickname:(please print): _____
(please print)

Date of Birth:_____/_____/_____Age:_____Name of school attending:_____ Grade level: _____

Other Household Members:

Name:	Age	Relationship to child/adolescent
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are there parents/guardians living at different addresses? ☐Yes ☐No

If yes, how may we reach them?_____

Please state your reason for contacting the Heritage Hospice Inc. Bereavement Department?_____

_____

Has your child had a physical/medical exam since the illness/death? ☐Yes ☐No

Has your child received any professional support since the illness/death? ☐Yes ☐No

If yes, please check all that apply:

☐Hospice Bereavement Care
☐Minister, Priest, Rabbi, etc.
☐Family Physician
☐School Counselor (Name):_____
☐Other Counselor (Name):_____
☐Other:_____

Is your child currently taking medications? ☐Yes ☐No

If yes, please list:_____

_____

Please assist us in understanding the facts that your child knows about the family member's illness or death?

As the child/adolescent been told the facts about the family member's illness or death? ☐Yes ☐No

Does the child/adolescent understand the facts about the family member's illness or death? ☐Yes ☐No

If no, to either of the above, please explain:_____

How would you describe the child's/adolescent's relationship with this person?_____

_____

2. INFORMATION ABOUT YOUR LOSS (if this does not apply to you, skip to section 3)

Name of the person who died:_____

Their relationship to your child:_____Date of death:_____

Age of deceased:_____Was this person a Hospice patient? ☐Yes ☐No

Place of death: ☐Home ☐Hospital ☐Other

Nature of death: ☐Illness ☐Accident ☐Homicide ☐Suicide

Is this your child's first experience of death? ☐Yes ☐No

Did your child attend the funeral/memorial? ☐Yes ☐No

3. PREVIOUS LOSSES

Relationship	Cause of Death	Date of Death

Please note any other recent losses, changes, stressors in your child's life (i.e. divorce, illness, move, finances):_____

_____

4. REACTION TO THE LOSS

Please place a "x" in the column that best answers the question.

General Questions/Behaviors Has your child shown any of the following behaviors?	Before illness/death	Since illness/death	Not at all
Refusal to believe or acknowledge			
Feeling angry a lot			
Feeling nervous or anxious			
General Questions/Behaviors Has your child shown any of the following behaviors?	**Before illness/death**	**Since illness/death**	**Not at all**
Worried about his/her safety or the safety of loved ones			
Always trying to act perfect/in control			
Expression of relief			
Belief that illness/death was his/her fault			
Belief that illness/death is a punishment			
Problems at work or in school			
Withdrawing from family and friends			
Problems sleeping			
Having disturbing dreams			
Problems with appetite			
Change in weight			
Headaches, stomach aches, backaches, etc.			

Increase in use of alcohol and/or drugs			
Change in how he/she feels about self			
Lack of energy			
Loss of interest in usual activities			
Exhibiting inappropriate and/or sexually acting out behavior			
Difficulty with concentration and/or memory			
Expressing longing to be with the deceased			
Expressing thoughts of suicide			
Expressing feelings of intense loneliness or isolation			
Having more accidents or injuries than usual			

Which of the following activities have been helpful to your child:

☐Talking with a friend ☐Talking with family
☐Writing or drawing ☐Talking or writing to person who died
☐Physical activity/sports ☐Visiting grave
☐Talking with other supportive person (i.e. minister, teacher)
☐Other:_____

5. OTHER IMPORTANT INFORMATION

Spiritual/Faith Based Practice History: _____
_____
_____

Are there other things we should know about your child? _____
_____
_____

How do you prefer our staff to contact you?

☐Telephone:_____ ☐Cell phone:_____

☐Email:_____

This bereavement history is correct to the best of my knowledge.

_____ _____
Signature ☐Parent ☐Legal Guardian **Date**

HERITAGE HOSPICE, INC. NOTICE OF HOSPICE PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

USE AND DISCLOSURE OF HEALTH INFORMATION

Heritage Hospice, Inc. may use your health information, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996, for purposes of providing you treatment, obtaining payment for your care and conducting health care operations. The Hospice has established policies to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Provide Treatment. The Hospice may use your health information to coordinate care within the Hospice and with others involved in your care, such as your attending physician, members of the Hospice interdisciplinary team and other health care professionals who have agreed to assist the Hospice in coordinating care. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. The Hospice also may disclose your health care information to individuals outside of the Hospice involved in your care including family members, clergy who you have designated, pharmacists, suppliers of medical equipment or other health care professionals.

To Obtain Payment. The Hospice may include your health information in invoices to collect payment from third parties for the care you receive from the Hospice. For example, the Hospice may be required by your health insurer to provide information regarding your health care status so that the insurer will reimburse you or the Hospice. The Hospice also may need to obtain prior approval from your insurer and may need to explain to the insurer your need for hospice care and the services that will be provided to you.

The Hospice must agree to your request to restrict disclosure of protected health information to a health plan if the information pertains solely to a healthcare item or service for which you have paid Heritage Hospice, Inc. in full.

To Conduct Health Care Operations. The Hospice may use and disclose health information for its own operations in order to facilitate the function of the Hospice and as necessary to provide quality care to all of the Hospice's patients. Health care operations includes such activities as:

- Quality assessment and improvement activities.
- Activities designed to improve health or reduce health care costs.
- Protocol development, case management and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of the Hospice.
- Fundraising for the benefit of the Hospice.

For example the Hospice may use your health information to evaluate its staff performance, combine your health information with other Hospice patients in evaluating how to more effectively serve all Hospice patients, disclose your health information to Hospice staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you as part of general fundraising and community information mailings. You have the right to opt out of receiving such communications.

For Fundraising Activities. The Hospice may elect to use information about you, upon obtaining written explanation/and authorization from you, for fundraising purposes.

Your information will not be released to a third party that intends to market products or services to you

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY ALSO BE USED AND DISCLOSED.

When Legally Required. The Hospice will disclose your health information when it is required to do so by any Federal, State or local law.

When There Are Risks to Public Health. The Hospice may disclose your health information for public activities and purposes in order to:

- Prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- Report adverse events, product defects, to track products or enable product recalls, repairs and replacements and to conduct post-marketing surveillance and compliance with requirements of the Food and Drug Administration.
- Notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease.
- Notify an employer about an individual who is a member of the workforce as legally required.

To Report Abuse, Neglect Or Domestic Violence. The Hospice is allowed to notify government authorities if the Hospice believes a patient is the victim of abuse, neglect or domestic violence. The Hospice will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To Conduct Health Oversight Activities. The Hospice may disclose your health information to a health oversight hospice for activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. The Hospice, however, may not disclose your health information if you are the subject of an investigation and your health information is not directly related to your receipt of health care or public benefits.

In Connection With Judicial And Administrative Proceedings. The Hospice may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Hospice makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by State law, the Hospice may disclose your health information to a law enforcement official for certain law enforcement purposes as follows:

- As required by law for reporting of certain types of wounds or other physical injuries pursuant to the court order, warrant, subpoena or summons or similar process.
- For the purpose of identifying or locating a suspect, fugitive, material witness or missing person.
- Under certain limited circumstances, when you are the victim of a crime.
- To a law enforcement official if the Hospice has a suspicion that your death was the result of criminal conduct including criminal conduct at the Hospice.
- In an emergency in order to report a crime.

To Coroners And Medical Examiners. The Hospice may disclose your health information to coroners and medical examiners for purposes of determining your cause of death or for other duties, as authorized by law.

To Funeral Directors. The Hospice may disclose your health information to funeral directors consistent with applicable law and if necessary, to carry out their duties with respect to your funeral arrangements. If necessary to carry out their duties, the Hospice may disclose your health information prior to and in reasonable anticipation of your death.

For Organ, Eye Or Tissue Donation. The Hospice may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs, eyes or tissue for the purpose of facilitating the donation and transplantation.

For Research Purposes. The Hospice may, under very select circumstances, use your health information for research. Before the Hospice discloses any of your health information for such research purposes, the project will be subject to an extensive approval process.

In the Event of A Serious Threat To Health Or Safety. The Hospice may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Hospice, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public.

For Specified Government Functions. In certain circumstances, the Federal regulations authorize the Hospice to use or disclose your health information to facilitate specified government functions relating to military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For Worker's Compensation. The Hospice may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Other than is stated above, the Hospice will not disclose your health information other than with your written authorization. If you or your representative authorizes the Hospice to use or disclose your health information, you may revoke that authorization in writing at any time. Heritage Hospice, Inc. is required to notify affected individuals following a breach of unsecured protected health information by a written letter sent by first class mail to the last known address of the affected individual(s).

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Hospice maintains:

- **Right to request restrictions**. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Hospice's disclosure of your health information to someone who is involved in your care or the payment of your care. The Hospice is not required to agree to your request. However, the hospice must agree to your request to restrict disclosure of protected health information to a health plan if the information pertains solely to a healthcare item or service for which you have paid Heritage Hospice, Inc. in full. If you wish to make a request for restrictions, please contact **The Director of Clinical Services**.

- **Right to receive confidential communications**. You have the right to request that the Hospice communicate with you in a certain way. For example, you may ask that the Hospice only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact **The Director of Clinical Services, 859-236-2425***.* The Hospice will not request that you provide any reasons for your request and will attempt to honor your reasonable requests for confidential communications.

- **Right to inspect and copy your health information**. You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to **The Director of Clinical Services, 859-236-2425***.* If you request a copy of your health information, the Hospice may charge a reasonable fee for copying and assembling costs associated with your request. Heritage Hospice, Inc. will provide you with access to an electronic form of your protected health information in a timely manner upon your request for such information.

- **Right to amend health care information**. You or your representative has the right to request that the Hospice amend your records, if you believe that your health information is incorrect or incomplete. That request may be made as long as the information is maintained by the Hospice. A request for an amendment of records must be made in writing to **The Director of Clinical Services, P.O. Box 1213, Danville, KY 40423.** The Hospice may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied, if your health information records were not

created by the Hospice, if the records you are requesting are not part of the Hospice's records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of the Hospice, the records containing your health information are accurate and complete.

- **Right to an accounting**. You or your representative has the right to request an accounting of disclosures of your health information made by the Hospice for certain reasons, including reasons related to public purposes authorized by law and certain research. The request for an accounting must be made in writing to **The Director of Clinical Services, P.O. Box 1213, Danville, KY 40423.** The request should specify the time period for the accounting starting on or after April 14, 2003. Accounting requests may not be made for periods of time in excess of six (6) years. The Hospice would provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee.

- **Right to a paper copy of this notice**. You or your representative has a right to a separate paper copy of this Notice at any time even if you or your representative has received this Notice previously. To obtain a separate paper copy, please contact **The Director of Clinical Services, 859-236-2425**.

DUTIES OF THE HOSPICE

The Hospice is required by law to maintain the privacy of your health information and to provide to you and your representative this Notice of its duties and privacy practices. The Hospice is required to abide by the terms of this Notice as may be amended from time to time. The Hospice reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all health information that it maintains. If the Hospice changes its Notice, the Hospice will provide a copy of the revised Notice to you or your appointed representative.

You or your personal representative has the right to express complaints to the Hospice and to the Secretary of DHHS if you or your representative believes that your privacy rights have been violated. Any complaints to the Hospice should be made in writing to **Director of Clinical Services.** The Hospice encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

The Hospice has designated the **Director of Clinical Services** as its contact person for all issues regarding patient privacy and your rights under the Federal privacy standards. You may contact this person at:

Heritage Hospice, Inc.
P.O. Box 1213
Danville, KY 40423
859-236-2425

EFFECTIVE DATE

This Notice is effective Aug 15, 2013.

IF YOU HAVE ANY QUESTIONS REGARDING THIS NOTICE, PLEASE CONTACT

Director of Clinical Services
Heritage Hospice, Inc.
P.O. Box 1213
Danville, KY 40423
859-236-2425
or
Regional Manager
Office for Civil Rights
Department of Health and Human Service
233 North Michigan Ave. Ste #240
Chicago, IL 60601