Community HOSPICE
Helping Hands...Healing Hearts

OFFICE USE ONLY
Interviewed by:_____
Date: _____

Children's Grief Program Services Request

Child's Name _____

Parent/Legal Guardian's Name _____

Address _____ Town: _____ State:_____ Zip: _____

Email _____ Telephone (home) _____ (cell) _____

DOB: _____ Age _____ Ethnicity (Opt.) _____ School _____

Please provide the following information about the person who died:

Name _____ Child's Relationship to Deceased _____

Date of Death _____ Cause of Death _____

Other helpful information about the deceased/death _____

Is this the first direct experience that the child has had with death? ❑ YES ❑ NO

Has the grieving child had any of the following behaviors since the death experience?

- ❑ Afraid to go to sleep
- ❑ Nightmares
- ❑ Bed wetting
- ❑ Anxiety
- ❑ Destructive behavior
- ❑ Anger
- ❑ Clinging to parent/guardian
- ❑ Difficulty with schoolwork
- ❑ Cruelty to animals
- ❑ Using alcohol/drugs
- ❑ Isolated at home/school
- ❑ Causing harm to self
- ❑ Refuses to talk about the death
- ❑ Behavior Problems at home/school
- ❑ Other: _____

Is the child currently receiving any counseling and/or psychiatric care? ❑ YES ❑ NO

If yes who? _____

Name(s) of who child lives with	Age	Sex	Relationship

Is there anything else we should do to better serve your child?

_____

_____

_____

Parent/Legal Guardian Signature _____ **Date** _____

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Bereavement Services Participation Agreement

I hereby consent and authorize Community Hospice, its employees, volunteers, agents and associates to provide bereavement services for me, and/or my child, either individually or in a group setting.

I understand that my/their participation is voluntary and I/we am/are responsible for my/their own attendance and follow up. I agree to notify the Community Hospice Bereavement Department staff of any significant event which would affect my/their participation in bereavement services, and/or inability to participate or continue with bereavement services.

I further understand that the grief support groups are facilitated by trained hospice volunteers. The Community Hospice staff that provides grief support is professionally trained. I understand that the support group meetings and the individual grief support available to me and/or my child do not serve as a substitute for therapy/counseling services. I agree to indemnify and hold harmless and defend the other party, its directors, officers, employees, volunteers and agents from and against any and all claims, suits, damages, fines, penalties, liabilities and expenses, including reasonable attorney fees and court costs, resulting from or arising out of any claimed willful or negligent act or omission pertaining to services rendered hereunder. This indemnification provision shall survive termination or expiration of this agreement.

I understand that Community Hospice employees and volunteers are mandated reporters. As such, if they have reason to believe that a minor child or dependent adult has been abused or neglected they are required to report to the appropriate agency. In addition, if I intend to harm myself or someone else, Community Hospice employees and volunteers are required to take steps, which may include sharing confidential information with others, in order to keep me and others safe.

I acknowledge that Community Hospice respects clients rights to privacy at all times, and information is held in the strictest confidence by their employees, volunteers and agents. Community Hospice complies with all legal requirements of the Health Insurance Portability Act (HIPAA). A Notice of Privacy is available to me upon my attendance at a bereavement counseling or group service and representatives of this organization can explain my rights and responsibilities and answer my questions satisfactorily. Further, I/my child understand and agree that any and all confidential information made available to me in any way either organizationally or from other individuals will be held in the strictest confidence.

This Bereavement Services Participation Agreement is applicable only to my utilization of the bereavement services provided at Community Hospice. I agree to the terms and conditions as stated above, and that either party may terminate this agreement at any time.

Printed names:	Signatures:	Dates:
_____	_____	_____
Minor Child's Name, if applicable		
_____	_____	_____
Client/Parents/Legal Guardian		
_____	_____	_____
Organization Representative		