

Vandalia Health, PLLC / Sartell Family Medicine

2151 Troop Drive, Suite 100
Sartell, MN 56377

Non-discrimination Notice

- Our Organization complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex.
- Our Organization does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
- Our Organization provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
 - Free language interpreters and information written in other languages people whose primary language is not English.
- If you need these services, contact **Heather Rimmel, LPN (Clinic Manager)**.
- If you believe our Organization has failed to provide these services or discriminated in another way on the basis of race, color, national origin, disability, or sex, you can file a grievance with:

Heather Rimmel, LPN (Clinic Manager)
2151 Troop Drive, Suite #100
Sartell, MN 56377
E-Mail: heather.remmel@vandaliahealth.com
Phone: (320) 566 – 2151 Fax: (320) 245 – 1003

- You can file a grievance in person or by mail, fax, or e-mail. If you need help filing a grievance, **Heather Rimmel, LPN (Clinic Manager)** is available to help you.
- You can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:
 - Electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>

- By mail at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F HHH Building, Washington, D.C., 20201
- By phone at: 1-800-368-1019; 1-800-537-7697 (TDD)
- Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>

Non-discrimination Notice Signature Page

I have received and reviewed this information.

Patient Name

Guardian Name (if under 18)

Signature

Date

Witness

Date