



Community Services Feedback Form

Our service is committed to providing high-quality care and services to meet your needs. We value your feedback – including complaints. Please let us know what we do well and where we can improve our services. If you have any immediate concerns, please talk to a staff member so the matter can be resolved.

Date:

Compliment

Suggestion

Complaint

Please indicate who is providing the feedback:

- Client Relative Client Representative Volunteer Staff Member
 Other: _____

Depending on the nature of your feedback if you choose to remain anonymous, SACAL may be unable to respond appropriately.

Name:
Postal Address:
Telephone Number: Mobile Number:
Email Address:

Do you require an interpreter No Yes, which language?

- I would like to discuss feedback with Manager
 I would like to discuss feedback with General Manager

Please provide details of your main concerns, including what events led to making the complaint, compliment or feedback, approximate dates and who was involved.

What action have you already taken in relation to this feedback?

Have you discussed your concerns with the or another person for assistance with these concerns? Yes No
If **yes**, with whom and what was the outcome?

What outcomes would you like as a result of providing your feedback?



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How to return your feedback:

Provide to any staff member or contact 6581 6800, or visit Bourne House
Level 1, 10-12 Short Street, Port Macquarie
or mail to
PO BOX 104 Port Macquarie,

Privacy

The organisation is committed to protecting your privacy. We collect and handle personal information that you provide on this feedback form for the purpose of investigating and responding. We will only use your information in accordance with relevant privacy and other laws. In order for us to provide services to you effectively and efficiently, we may need to share your personal information with others that deals with the matters identified in your feedback.

OFFICE USE ONLY

Date complaint Received: Verbal Complaint Written Complaint
Name of Team Leader/Manager dealing with the complaint:

ACTION OF TEAM LEADER OR MANAGER:	Date:	<input type="text"/>

MANAGER USE ONLY

FINAL OUTCOME:	Date:	<input type="text"/>

HOW THE PERSON WAS KEPT INVOLVED THROUGHOUT THE PROCESS:

Entered to Complaints Register No Yes
Opportunity for improvement? No Yes - Quality & Compliance Team to add to Continuous improvement Plan

Manager Name: Manager Signature: