

**Complaint Form**

Name:

Age of client:

*NB If the client is under 16 years of age, a parent/guardian signature is required*

Please tick: [ ]  I am a client receiving the service

 [ ]  I am a family member, guardian or advocate of the client [ ]  I am an employee

 [ ]  I wish to remain anonymous

**Service Area:** [ ]  Accommodation - Address:

 [ ]  Day Program: [ ]  CP, 35 Beach St, Kogarah

 [ ]  CAS, 2 Laycock Road, Penshrurst

 [ ]  Coffee Club

 [ ]  Therapy Services

Date of Complaint:

Contact details:

**Please outline the details of your complaint:**

*Please tell us your main concerns, including what led up to the complaint and who was involved.*

**Please outline what you would like to happen to resolve your complaint:**

*Signed:*

*Parent/Guardian signature:*

***Please kindly send this complaint to:***

**ATTN: Office Manager**  Phone: 02 9588 5433

Address: Sunnyhaven Disability Services Fax: 02 9588 5066

 35 Beach Street, Kogarah NSW 2217

**Sunnyhaven use only:**

Complaint manage by:       Log No.

Date:

Action to be taken: [ ]  YES [ ]  NO

**Complaint Investigation**

*Describe the actions taken to follow up the concerns*

**Complaint Resolution**

*Describe the outcome of the complaint*

Investigation Response letter sent to family: [ ]  YES [ ]  NO

Please attach any supporting documentation and Response letter to this form.

Complaint closed:

By:

Date:

**Managers Only**

*Have you included this is your Monthly report – (Customer Service)* [ ]  YES [ ]  NO