Complaint Form 

**Please complete this Form if you have a complaint about AGAPI Care Inc Services.**

**If you need assistance to complete this form please contact the Manager Client Services & Partnerships (details below). AGAPI Care will help you get an advocate if you require one.**

**Section 1 – Contact Details**

*Please provide your details below if you are the person who received the service*

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Telephone (Business Hours) / Mobile** |  |
| **Email address** |  |
| **Do you require the services of an interpreter/translator?** | Yes  No  If **Yes,** which one do you require? |
| **Please tell us what help you may need to communicate with us** |  |
| **I wish to be identified as a person of Aboriginal and / or Torres Strait Islander descent.** | |

**Section 2: Complaint made on another person's behalf**

*If you are making a complaint on behalf of a person with a disability who received the service please fill in the following details about the person you are acting on behalf of.*

|  |  |
| --- | --- |
| **Name** |  |
| **Address** |  |
| **Telephone /Mobile** |  |
| **Email address** |  |
| **Do they require the services of an interpreter/translator?** | Yes  No  If **Yes**, which one do you require? |
| **Please tell us what help they may need to communicate with us** |  |
| **The person wishes to be identified as a person of Aboriginal and / or Torres Strait Islander descent.** | |
| **Please complete details of your relationship to the person who received the service and their knowledge of this complaint** | |
| **Your relation to the person who received the service** *(eg parent, advocate, carer etc)* |  |
| **Do you have a legal role for the person who received the service?** *(e.g. parent of a child under 18 years or guardian)* | Yes  No  If **Yes** please provide details |
| **Does the person know you are making a complaint on their behalf?** | Yes  No  If **No** please provide reasons why |

**Section 3: your concerns**

***Please tell us what your main concerns are, including what events lead to making the complaint, approximate dates and who was involved.*** *If you need more room to write information, please attach extra pages and any other relevant information.*

|  |  |
| --- | --- |
| **Service Name & Service type the complaint is about** (*eg Respite/ELPIDA/Referral/Advocacy etc)* |  |

**What is your complaint? (who, what, where, when, witnesses)**

|  |
| --- |
|  |

**What would you like to see happen about your complaint?**

|  |
| --- |
| *Please outline the things you want to happen to resolve your complaint.* |

|  |  |
| --- | --- |
| **Signature** |  |
| **Print Name** |  |
| **Date** |  |

**PRIVACY STATEMENT**

AGAPI Care is committed to protecting your privacy. This commitment arises not only from a wish to comply with legal obligations but also in recognition of and commitment to information privacy as one of the foundations of human dignity. AGAPI Care will collect and handle personal information that you provide on this complaints form for the purpose of investigating and responding to your complaint. We will only use your information in accordance with relevant privacy and other laws. You can request access to your personal information from the Client Services Manager.

**RETURN THE COMPLAINT FORM TO:**

**Manager Client Services & Partnerships, AGAPI Care Inc.**

**12 Showers Street Preston VIC 3072 (mail or in person) or**

**Fax: (03) 9489 0789 Email:** [**quality@agapicare.org.au**](mailto:quality@agapicare.org.au) **Phone: (03) 9416 9768**

**OFFICE USE ONLY**

**Date Complaint Received:** 🞎written (mail/faxed/email) 🞎personal contact 🞎 phone

**Staff Name [person receiving complaint]**

**Assessed (date): Complaints Register updated (date): Complaint Acknowledged (date):**

*(same working day) (within one day of receiving the complaint)* (*within two working days)*

**🞎 Action Plan required Manager’s Signature:**