



PARTICIPATION SUPPORT SERVICES **Consumer Concern Report**

Date of Concern: _____ **Time of Concern:** _____ **AM/PM**

Program Area:

- | | | |
|--|---|--|
| <input type="checkbox"/> 10 Bell Lane | <input type="checkbox"/> Stedman House | <input type="checkbox"/> Let's Go Home (LEGHO) |
| <input type="checkbox"/> 255 Colborne Street | <input type="checkbox"/> Attendant Outreach | |

Choose which category applies:

- | | | |
|---|---|--|
| <input type="checkbox"/> Eligibility decision | <input type="checkbox"/> Service exclusion | <input type="checkbox"/> Amount of service |
| <input type="checkbox"/> Service termination | <input type="checkbox"/> Quality of service | <input type="checkbox"/> Violation of rights under HCCSA |

Please detail your concern (incident, place, who, when, etc.) If you feel it necessary not to use names we ask you to use a generic term (i.e. staff)

Should you require additional space to complete your comments please attach additional pages to this form. Please forward the completed form to the Manager in the appropriate department.

Consumer Name

Witness name (relationship)

Consumer Signature

Witness name (relationship)

Date: _____

Date: _____

Date received: _____ **Manager's Signature:** _____

Summarize outcome of investigation & corrective action (if required)

Consumer Satisfied

Consumer Dissatisfied

Follow-up Required

Concern investigated by: _____ Date: _____

Response to:

1) Consumer

Date: _____

2) Staff Member

Date: _____

3) Executive Director

Date: _____