

**CLIENT AND COMMUNITY FEEDBACK**

**Please select your type of feedback – (Please Circle)**

Feedback Compliment Complaint Program feedback

**YOUR DETAILS**

First name: ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you wish to be contacted?** **(Please Circle)** YES NO

**How can we contact you? - (If yes, please enter preferred contact)**

Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Postal Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you wish to remain confidential?** **(Please Circle)** YES NO

**Are you:- (Please Tick Box )**  
  
 A Client

A Relative of a Client

A Friend of a Client

A Community Member

A Service Provider

**For what ASG service are you providing feedback for? – (Please Tick Box)**

Arkaringa House

Riverland Services

Substance Misuse Team

Mobile Assistance Patrol

CLH & AKH Hostels – (Homelessness Program)

Lakalinjeri Tumbetin Waal (Men’s Rehabilitation Facility)

Leila Rankine – House of Hope (Women’s Rehabilitation Facility)

Corporate Services – Head Office

**Please provide your feedback on the page attached**

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