Complaints Management Form

My Mobile Plan Manager
Your Trusted NDIS Accountant

Dear participant:

Please complete the following form in the unfortunate event of any incident occurring that did not meet your expectations of care. A formal investigation will commence once we receive the completed form. If you require assistance in the completion of this form, please contact us with provided details.

Complaint details to be completed by Participant/Participant's family

Participant name:		Phone:	
Participant's family name:		Phone:	

Date of incident:		Time:		Date of report:	
Location:					
Witness name (if applicable):		Phone:			
Address:					
Worker encountered during the incident:					
Description of Complaint:					

Immediate actions and measures taken by provider in response to the issue:

Immediate actions and measures were satisfactory?	☐ Yes ☒ No

Comments:

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Sign off		
Report completed by:		Signature:
Date:	DD / MM / YYYY	
Investigation to be completed by Provider		
Preliminary findings:		
Identified root causes:		
☐ Skills and competence	☐ Workplace Environment	☐ Policies & procedures
☐ Communication	☐ Risk assessment	☐ Others:
Required Actions		
Description of actions:		

Responsible:			Position:		Phone:	
Deadline:	DD / MM / YYYY	Status:	☐ Open	☐ More action required	☐ Closed effectively	
Comments:						

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Outcomes:			
☐ Run training/induction session		☐ Review/amend relevant process/documents	
☐ Review/update risk register		☐ Create new procedure	
☐ Others:			
Notification			
NDIS consultation required?	☐ Yes ☐ No	If yes; date of consultation:	DD / MM / YYYY
Complaint resolved?	☐ Yes ☐ No	Results communicated with Participant?	☐ Yes ☐ No
Sign off			
Investigation completed by:		Signature:	
Date:	DD / MM / YYYY		