# Hometown Health Centers

## COMPLAINT FORM

Date complaint form completed: _____ Date and time of incident: _____

Name of person making complaint: _____

Address: _____ Phone #: _____

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Description of incident: _____

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Person completing form: _____ Title: _____

If requested, a written response will be completed and sent to the complainant within 30 days.

If the reply is not satisfactory, the complainant can complain to the NYSDOH. HHC will provide the address.

**1044 State Street**
**Schenectady New York 12307** **POLICY # ADM.35**
**Telephone: (518) 370-1441 Fax: (518) 346-3526**