Hometown Health Centers

COMPLIMENT / COMPLAINT FEEDBACK FORM

Date form completed: _____ Date/time for reason of feedback: _____

Name of person providing feedback: _____

Address: _____ Phone #: _____

City: _____ State: _____ Zip: _____

Please provide detailed feedback of a Compliment or a Complaint below:

_____

_____

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Person completing form: _____

Relationship to person providing feedback: _____

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

The individual providing feedback can also contact NY State Department of Health if their feedback or concerns were not met satisfactorily.

Hometown Health Centers
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(518) 370-1441 | hometownhealthcenters.org