**Financial Assistance Appeal Request Form**

Please complete this form if you disagree with our decision on your financial assistance eligibility. Remember that our decision is based on the financial assistance application you filled out and supporting documents you provided.

**Patient information**

- Last name:
- First name:
- Date of birth:
- MRN (if known):

**Family information**

List any family members who also applied for financial assistance.

- Last name First name Date of birth Relationship to you

**Appeal information**

What part of your application do you think we were wrong about based on our financial assistance policy? Salem Health's Financial Assistance Policy can be found at www.salemhealth.org/financialassistance. Please write below why you think the financial assistance decision was incorrect.

Return this form and supporting documents that support your view using one of the methods below:

- **Email**: financialcounselors@salemhealth.org
- **Fax**: 503-814-1998
- **Mail**: Salem Health Financial Counselor Team, PO Box 14001, Salem, OR 97309-50141
- **In person**: Information Desk in Bldg. A at Salem Health's main campus or at West Valley Hospital's front desk in the lobby

Once we receive your appeal, we will respond within 21 days. We may need to ask you for more information before we can make a decision.

If you have any **questions**, please call us at 503-562-4357, Monday through Friday from 8:30 a.m. to 4 p.m.