River Hospital *Serving the Thousand Islands Region*

4 Fuller Street • Alexandria Bay • New York • 13607
315-482-2511 telephone
315-482-4981 facsimile

Notice of Right to Appeal Financial Aid Determination

Patient Name:_____ Date of Decision:_____

River Hospital, Inc. made a determination of financial aid based on the income levels you provided with your application. Other factors may not have been considered in the determination. You may appeal the Hospital's determination of financial aid if you disagree with the decision or feel you have additional hardships such as excessive medical bills that should be considered.

In order to appeal this decision you must return this form within 30 days. At that time the appeals committee will review this request and make a decision. You will be notified within 30 days of the decision on the appeal request.

Please provide an explanation for your request. Include specific information regarding why you disagree with the decision or what hardships would prevent you from contributing to your healthcare costs at the rate determined by the Financial Aid Committee in the original decision.

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Please forward this appeal with any additional documentation not submitted with your original application. Call Cherie at 482-1230 if you have any questions about this process.

Signature:_____ Date:_____