Budget Increase Appeal Form

Financial Aid Office | Western University of Health Sciences | 309 E. 2nd St., Pomona, CA 91766 | finaid@westernu.edu | (909) 469-5353

Last Name **First Name** **ID Number @** **Program/Grad Year**

REASON FOR APPEAL: Please explain in detail the extenuating circumstances that you believe warrant a second review of your original request. Please provide supporting documentation if necessary to support your appeal:

Your request must be submitted 10 days prior to the end of the academic year. Failure to meet this timeframe will warrant an automatic denial.

By signing below, I certify that all information reported on this appeal and supporting documentation is true to the best of my knowledge. Additionally, I understand that if the circumstances change, it is my responsibility to immediately notify the Financial Aid Office. Failure to do so may require me to repay any aid that was awarded based on incorrect or misrepresented information.

Student Signature ***Date***

OFFICE USE ONLY ❒ Approved ❒ Denied

COMMENTS:

Counselor Signature: _____ **Date:** _____

Director Signature: _____ **Date:** _____