ST. JOSEPH CHRISTIAN FORMATION MINISTRY

*FAMILY FINANCIAL NEED

FAMILY NAME: ____

ADDRESS: ____

P.O. BOX: ____

CITY, STATE, ZIP: ____

HOME PHONE: ______________________

Student Name: ______________________________ Grade Level: __________

Student Name: ______________________________ Grade Level: __________

Student Name: ______________________________ Grade Level: __________

Student Name: ______________________________ Grade Level: __________

Student Name: ______________________________ Grade Level: __________

Total Amount of Program Fees: $______________

Our Family Will Be Responsible For: $______________

Our Family Requests Financial Aid For: $______________

(responsible for **25% minimum – contact us at 262-662-3317 to set up a payment plan)

***Briefly describe the situation prompting this application:**

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____

Parent Signature: ____

* **DUE TO JOB LOSS, ILLNESS, OR DIFFICULT CIRCUMSTANCES.**

** **SOME MONETARY AMOUNT IS REQUIRED.**