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:**

_____

_____

Parent Signature: _____

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

** **SOME MONETARY AMOUNT IS <u>REQUIRED</u>.**