

**LAFAYETTE CATHOLIC SCHOOL SYSTEM  
REQUEST FOR ADDITIONAL AID  
2024-25 School Year**



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Parent 1 Last Name (as it appears on the Student Aid application)      Parent 1 First Name      Parent 2 First Name

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Phone Number

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Email Address

Desired Monthly Payment (over 10 months): \$ \_\_\_\_\_

Total Requested Additional Amount: \$ \_\_\_\_\_

Please describe your circumstances that cause your family to require additional Student Aid.

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Continue on back if needed

**Submit form to:**  
Barb Schummer, Student Aid Coordinator      Admissions & Student Aid Office  
bschummer@lcss.org      2410 S. 9<sup>th</sup> St.  
FAX: 765.474.5426      Lafayette, IN 47909