Bishop Rosecrans High School Tuition Aid Application

Parent/Guardian Name_____

Number of Dependents:_____

Name of children attending Bishop Rosecrans and/or Bishop Fenwick Schools

_____

_____

Payment amount your family can afford each month for 10 months beginning in August and ending in May each school year _____(an amount is required)

Please share any information that you believe would be helpful in evaluating your tuition assistance request below. You may continue on the reverse of this page, if needed.

I certify that the above information is correct and may be used by Bishop Rosecrans High School in addition to the Diocese of Columbus FACTS Tuition Aid results, to aid in determining tuition assistance.

Parent/Guardian Signature_____Date_____