Greenville
NORTH CAROLINA
RECREATION AND PARKS

FINANCIAL ASSISTANCE THROUGH FEE REDUCTION

City of Greenville residents may request a reduction in program fees when a need exists. These requests must be made in-person at Jaycee Park, 2000 Cedar Lane Greenville NC 27858, at least one week prior to the program's registration deadline. Requests will be evaluated based on overall household income and size as determined by the State of North Carolina's Medicaid program through verification by possession of a current Medicaid card, Food Assistance and Nutrition Program approval letter or Health Choice card. This option does not exist for non-City residents.

All requests for fee reduction will be approved or denied by the Director of Recreation and Parks or a designee. As of July 1, 2016, all registrants will be required to pay a minimum of $10.00 for each registration and will be limited to a maximum of $150.00 in assistance per person during a 12 month period.

Financial Assistance is not available for Greenville Aquatics and Fitness Center memberships, organizations, clubs, adult teams, special event fees, workshops, golf course, trips or rentals.

HOUSEHOLD INFORMATION

The City of Greenville Recreation and Parks Department wants all Greenville citizens to have the opportunity to participate in recreational programs. For those who have current financial need, some assistance may be available. Persons requesting assistance must be able to substantiate need by submitting a current form of one of the following:

1. Medicaid Card
2. Food Assistance and Nutrition approval letter
3. Health Choice card.

Participant's Name(s):_____ _____

Recreation Program: _____ Total Program Fee: $_____

Amount of fee assistance requested: $_____ Total Amount owed: $_____

Parent/Guardian Name: _____

I certify that all the information on this application is true and correct.

_____ _____
Signature of Adult Household Member Date

_____ _____
Print Name Street Address

_____ _____ _____
Home Phone Number Work Phone Number Cell Number

FOR OFFICE USE ONLY

Date received_____ Copy of current Medicaid/Health Choice/Food Assistance attached_____

Approved at rate of_____ Denied_____ Signature of Director/Designee_____

Doc #1187899