



COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF REVENUE

APPLICATION FOR SALES TAX EXEMPTION

(Must be completed in black ink.)

EXEMPTION NUMBER: _____
DATE OF ACTION: _____
DENIAL REASON: _____
EVALUATOR: _____

SECTION 1 - REGISTRATION

INSTITUTIONS SEEKING EXEMPTION FROM SALES AND USE TAX MUST COMPLETE THIS APPLICATION. SECTION 1 -- REGISTRATION MUST BE COMPLETED BY ALL INSTITUTIONS. PLEASE FOLLOW THE INSTRUCTIONS CAREFULLY TO INSURE ALL PERTINENT INFORMATION AND SUPPORTING DOCUMENTATION ARE SUPPLIED.

CHECK THE APPROPRIATE BOX TO INDICATE THE REASON FOR THIS REGISTRATION.

☐ NEW REGISTRATION ☐ EXPIRED EXEMPTION STATUS ☐ RENEWAL UPDATE

REQUIRED DOCUMENTATION CHECKLIST

- ☐ INCORPORATED INSTITUTIONS MUST PROVIDE A COPY OF THE ARTICLES OF INCORPORATION SPECIFICALLY INCLUDING A PROVISION PROHIBITING THE USE OF ANY SURPLUS FUNDS FOR PRIVATE INUREMENT TO ANY PERSON IN THE EVENT OF A SALE OR DISSOLUTION OF THE INSTITUTION.
- ☐ UNINCORPORATED INSTITUTIONS MUST PROVIDE A COPY OF THE BY LAWS OR ANY GOVERNING DOCUMENT SPECIFICALLY INCLUDING A PROVISION PROHIBITING THE USE OF ANY SURPLUS FUNDS FOR PRIVATE INUREMENT TO ANY PERSON IN THE EVENT OF A SALE OR DISSOLUTION OF THE INSTITUTION.
- ☐ ALL ORGANIZATIONS MUST PROVIDE A COPY OF THE MOST CURRENT FINANCIAL STATEMENT (NEW ORGANIZATIONS CAN SUBSTITUTE A PROPOSED BUDGET) INCLUDING ALL INCOME AND EXPENSES LISTED BY SOURCE AND CATEGORY.
- ☐ IF THE INSTITUTION HAS BEEN GRANTED EXEMPTION BY THE INTERNAL REVENUE SERVICE (IRS), PROVIDE A COPY OF THE DETERMINATION LETTER.
- ☐ IF THE INSTITUTION FILES FORM 990, PROVIDE A COPY OF THE MOST RECENTLY COMPLETED FORM WITH THE APPLICATION.

SUBSECTION A - INSTITUTION INFORMATION

INSTITUTION LEGAL NAME		FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN) *	
INSTITUTION TRADE NAME (IF DIFFERENT THAN LEGAL NAME)		INSTITUTION TELEPHONE NUMBER	
INSTITUTION STREET ADDRESS (do not use PO box)			
CITY	STATE	ZIP CODE	DATE OF FIRST OPERATIONS
LOCATION OF INSTITUTION RECORDS (street address)		CITY	
COUNTY	STATE	ZIP CODE	
INSTITUTION MAILING ADDRESS (if different than street address)		CITY	STATE ZIP CODE

SUBSECTION B - FORM OF ORGANIZATION

CHECK THE APPROPRIATE BOX: ☐ CORPORATION ☐ ASSOCIATION ☐ OTHER _____

DATE OF INCORPORATION _____ STATE OF INCORPORATION _____

IS THE INSTITUTION ORGANIZED FOR PROFIT OR NONPROFIT? ☐ PROFIT ☐ NONPROFIT

IF THE INSTITUTION QUALIFIES AS EXEMPT FROM TAXATION THROUGH THE INTERNAL REVENUE SERVICE, INDICATE UNDER WHICH SECTION THE ORGANIZATION QUALIFIES: 501(C)(_____)

IF THE INSTITUTION HAS PREVIOUSLY BEEN GRANTED TAX EXEMPT STATUS FROM THE INTERNAL REVENUE SERVICE, HAS THAT STATUS CHANGED WITHIN THE PAST FIVE YEARS? ☐ YES ☐ NO

HAS THERE BEEN A COURT DECISION IN PENNSYLVANIA OR ANY OTHER JURISDICTION THAT AFFECTS THE INSTITUTION'S LOCAL OR STATE TAX EXEMPTION WITHIN THE PAST FIVE YEARS? ☐ YES ☐ NO

IS YOUR TAX EXEMPT STATUS CURRENTLY BEING CHALLENGED BY THE INTERNAL REVENUE SERVICE, THE COMMONWEALTH OF PENNSYLVANIA, A POLITICAL SUBDIVISION, OR A FOR PROFIT ENTITY? ☐ YES ☐ NO

* All organizations that have been granted 501(c) 3 tax exemption status by the United States Federal Government should supply their Federal EIN Number.



APPLICATION FOR SALES TAX EXEMPTION

SUBSECTION C - ORGANIZATION INFORMATION

PROVIDE A DETAILED DESCRIPTION OF THE PAST, PRESENT, AND PLANNED FUTURE ACTIVITIES OF THE INSTITUTION FOR A PERIOD OF THREE YEARS. INCLUDE A DESCRIPTION OF HOW BENEFICIARIES ARE SELECTED.

SUBSECTION D - AFFILIATE INFORMATION

ARE YOU A NONPROFIT PARENT CORPORATION THAT ELECTS TO BE CONSIDERED AS A SINGLE INSTITUTION IN CONJUNCTION WITH YOUR SUBSIDIARY WHO IS AN INSTITUTION OF PURELY PUBLIC CHARITY?

☐ YES ☐ NO

ARE YOU AFFILIATED WITH ANOTHER ORGANIZATION?

☐ YES ☐ NO

LIST EACH AFFILIATE, AND THEIR ADDRESS, THE DATE OF AFFILIATION/SUBSIDIARY, PERCENT OF OWNERSHIP IN EACH, THE TYPE OF INSTITUTION, THE RELATIONSHIP, AND WHETHER IT IS ORGANIZED AS A PROFIT OR NONPROFIT INSTITUTION. ATTACH ADDITIONAL SHEETS IF NECESSARY OR AN ORGANIZATIONAL CHART.

NAME OF AFFILIATE	FEDERAL EIN NUMBER	PERCENT OF OWNERSHIP
ADDRESS		DATE OF AFFILIATION
TYPE OF ORGANIZATION	RELATIONSHIP	PROFIT OR NONPROFIT
NAME OF AFFILIATE	FEDERAL EIN NUMBER	PERCENT OF OWNERSHIP
ADDRESS		DATE OF AFFILIATION
TYPE OF ORGANIZATION	RELATIONSHIP	PROFIT OR NONPROFIT

SUBSECTION E - OFFICER INFORMATION

THIS SECTION MUST BE COMPLETED IN FULL BY EVERY INSTITUTION EVEN IF THE INSTITUTION DOES NOT COMPENSATE ITS OFFICERS. THE ANNUAL COMPENSATION SHOULD INCLUDE THE OFFICER'S SALARY FROM THE INSTITUTION, CONTRIBUTIONS MADE ON THE OFFICER'S BEHALF TO EMPLOYEE BENEFIT PROGRAMS AND DEFERRED COMPENSATION, EXPENSE ACCOUNT, AND ANY OTHER FORM OF COMPENSATION. ATTACH ADDITIONAL SHEETS IF NECESSARY. IRS FORM 990 MAY BE SUBSTITUTED.

LAST NAME	FIRST NAME	TITLE	ANNUAL COMPENSATION
OTHER BENEFITS AND AMOUNTS OF EACH			
LAST NAME	FIRST NAME	TITLE	ANNUAL COMPENSATION
OTHER BENEFITS AND AMOUNTS OF EACH			
LAST NAME	FIRST NAME	TITLE	ANNUAL COMPENSATION
OTHER BENEFITS AND AMOUNTS OF EACH			
LAST NAME	FIRST NAME	TITLE	ANNUAL COMPENSATION
OTHER BENEFITS AND AMOUNTS OF EACH			



APPLICATION FOR SALES TAX EXEMPTION

SUBSECTION F - SALARY INFORMATION All organizations must complete this information.

IS COMPENSATION BASED IN ANY WAY ON THE FINANCIAL PERFORMANCE OF THE INSTITUTION? ☐ YES ☐ NO
IF YES, PLEASE EXPLAIN ON A SEPARATE SHEET AND ATTACH IT TO THE APPLICATION.

DOES THE INSTITUTION APPLY OR RESERVE ALL REVENUE, INCLUDING CONTRIBUTIONS, IN EXCESS OF EXPENSES IN FURTHERANCE OF ITS CHARITABLE PURPOSE OR TO FUNDING OF OTHER INSTITUTIONS WHO ARE CONSIDERED INSTITUTIONS OF PURELY PUBLIC CHARITY? ☐ YES ☐ NO

DO ANY OF THE INSTITUTION'S NET EARNINGS OR DONATIONS THAT IT RECEIVES INURE TO THE BENEFIT OF PRIVATE SHAREHOLDERS OR INDIVIDUALS? ☐ YES ☐ NO

LIST POSITION, SALARY, AND OTHER COMPENSATION, INCLUDING BENEFITS, OF THE FOUR HIGHEST PAID INDIVIDUALS. DO NOT REPEAT THOSE OFFICERS LISTED IN SUBSECTION E (OFFICER INFORMATION). INDICATE IN THE SPACE ALLOTTED BELOW A STATEMENT INDICATING THE BASIS OF COMPENSATION. IF THE INSTITUTION IS COMPRISED ONLY OF VOLUNTEERS, SKIP THIS SECTION BY WRITING "NOT APPLICABLE". IF SCHEDULE A IS COMPLETED, IRS FORM 990 SCHEDULE A MAY BE SUBSTITUTED.

LAST NAME	FIRST NAME	POSITION	SALARY
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OTHER BENEFITS AND AMOUNTS OF EACH

LAST NAME	FIRST NAME	POSITION	SALARY
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OTHER BENEFITS AND AMOUNTS OF EACH

LAST NAME	FIRST NAME	POSITION	SALARY
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OTHER BENEFITS AND AMOUNTS OF EACH

LAST NAME	FIRST NAME	POSITION	SALARY
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OTHER BENEFITS AND AMOUNTS OF EACH

SECTION 2 - FINANCIAL DATA

PLEASE REFER TO THE INSTRUCTIONS BEFORE COMPLETING THIS SECTION. ALL INSTITUTIONS MUST COMPLETE SECTION 1.
INDICATE THE YEAR FROM WHICH FINANCIAL DATA WAS USED: _____

PART 1 - BASIC QUESTIONS

- (1) INCOME - LIST ALL OF THE SOURCES OF INCOME, INCLUDING CONTRIBUTIONS, RECEIVED AS PART OF THE INSTITUTION'S CHARITABLE PURPOSE. EXAMPLE CATEGORIES ARE LISTED. ADDITIONAL SOURCES SHOULD BE LISTED AND IDENTIFIED UNDER 'OTHER'. ATTACH ADDITIONAL SHEETS IF NECESSARY.

ACTIVITY	DOLLAR AMOUNT
CONTRIBUTIONS & DONATIONS	
FEES RECEIVED FOR GOODS OR SERVICES	
FEE-FOR-SERVICE PAYMENTS FOR ANY GOVERNMENTAL PROGRAMS	
GOVERNMENT SUPPORT (ie. GRANTS, FUNDING, etc.)	
OTHER, LIST:	

TOTAL REVENUE
(INCLUDING AMOUNTS LISTED
ON SEPARATE SHEETS) _____



APPLICATION FOR SALES TAX EXEMPTION

- (2) EXPENSES – LIST THE EXPENSES DIRECTLY RELATED TO THE INSTITUTION'S CHARITABLE PURPOSE AND THEIR RESPECTIVE AMOUNTS. ATTACH ADDITIONAL SHEETS TO THE APPLICATION. (NOTE: ANY EXPENSES NOT INCLUDED IN THIS SECTION MAY BE SUBJECT TO A SALES OR USE TAX.) IRS FORM 990 MAY BE SUBSTITUTED.

ACTIVITY	DOLLAR AMOUNT
TOTAL EXPENSES (INCLUDING AMOUNTS LISTED ON SEPARATE SHEETS)	

- (3) DOES THE INSTITUTION HAVE A VOLUNTARY AGREEMENT (i.e. PILOT, SILOT, etc.) WITH A POLITICAL SUBDIVISION? ATTACH A COPY OF EACH AGREEMENT WITH THE APPLICATION. ☐ YES ☐ NO
- (4) VOLUNTEERS – THE INSTITUTION MAY ELECT TO LIST THE NAME OF EACH VOLUNTEER, ALONG WITH THE NUMBER OF HOURS WORKED EACH WEEK AND THE NUMBER OF WEEKS VOLUNTEERED FOR THE YEAR. ALTERNATIVELY, THE INSTITUTION MAY BREAK OUT THEIR LIST ACCORDING TO THE NUMBER OF VOLUNTEERS WHO CONTRIBUTE THE SAME NUMBER OF HOURS EACH WEEK AND WEEKS EACH YEAR. A LISTING BY NAMES AND HOURS WORKED SHOULD BE AVAILABLE FOR INSPECTION BY THE DEPARTMENT IF REQUESTED. ATTACH ADDITIONAL SHEETS AS NEEDED.

YEAR FROM WHICH VOLUNTEER DATA WAS GATHERED: _____

NAME OF INDIVIDUAL OR NUMBER OF INDIVIDUALS	HOURS PER WEEK	WEEKS PER YEAR

- (5) A. HOW MANY PEOPLE RECEIVE GOODS OR SERVICES FROM THE INSTITUTION? _____
B. HOW MANY REGISTERED MEMBERS ARE IN YOUR ORGANIZATION/CHURCH? _____
- (6) HOW MANY PEOPLE RECEIVE THE GOODS OR SERVICES FOR FREE? _____
- (7) HOW MANY PEOPLE PAY A REDUCED FEE FOR THE GOODS OR SERVICES? _____
- (8) DO ANY OF THE PEOPLE RECEIVING GOODS OR SERVICES PAY A FEE WHICH IS EQUAL TO OR GREATER THAN THE COST OF THE GOODS OR SERVICES PROVIDED TO THEM? ☐ YES ☐ NO
- (9) WHAT NUMBER OF INDIVIDUALS RECEIVE FINANCIAL ASSISTANCE FROM THE INSTITUTION? _____
- (10) AFTER SUBTRACTING THE FINANCIAL ASSISTANCE GRANTED BY THE INSTITUTION, HOW MANY INDIVIDUALS PAID A FEE 90% OR LESS OF THE COST OF THE GOODS OR SERVICES PROVIDED TO THEM? _____

Emergency Health and Safety Service Institutions and religious organizations should stop here and turn to page 12 and complete the Authorized Signature.

PART 2 – RECIPIENT INFORMATION

- (1) WHAT PERCENTAGE OF INDIVIDUALS RECEIVING GOODS OR SERVICES FROM THE INSTITUTION RECEIVE A REDUCTION IN FEES OF AT LEAST 10% OF THE COST OF THE GOODS OR SERVICES PROVIDED TO THEM? _____
- (2) WHAT IS THE COST OF PROVIDING COMMUNITY SERVICES PROVIDED BY OR PARTICIPATED IN BY THE INSTITUTION? ATTACH A COPY OF SUPPORTING DOCUMENTATION TO THE APPLICATION. _____
- (3) WHAT AMOUNT DOES THE INSTITUTION RECEIVE AS PAYMENTS TO SUPPORT SUCH COMMUNITY SERVICES? ATTACH A COPY OF SUPPORTING DOCUMENTATION TO THE APPLICATION. _____



APPLICATION FOR SALES TAX EXEMPTION

(4) WHAT IS THE COST OF PROVIDING EDUCATION AND RESEARCH PROGRAMS PROVIDED BY OR PARTICIPATED IN BY THE INSTITUTION? ATTACH A COPY OF SUPPORTING DOCUMENTATION TO THE APPLICATION.

(5) WHAT AMOUNT DOES THE INSTITUTION RECEIVE AS PAYMENT TO SUPPORT ITS EDUCATION AND RESEARCH PROGRAMS? ATTACH A COPY OF SUPPORTING DOCUMENTATION TO THE APPLICATION.

- | | | | | | | |
|-----|-----|---|--------------------------|-----|--------------------------|----|
| (6) | (A) | DOES THE INSTITUTION PROVIDE GOODS OR SERVICES TO INDIVIDUALS WITH MENTAL RETARDATION OR TO INDIVIDUALS WHO NEED MENTAL HEALTH SERVICES? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| | (B) | DOES THE INSTITUTION PROVIDE GOODS OR SERVICES TO MEMBERS OF AN INDIVIDUAL'S FAMILY OR GUARDIAN IN SUPPORT OF SUCH GOODS OR SERVICES? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| | (C) | DOES THE INSTITUTION PROVIDE GOODS OR SERVICES TO INDIVIDUALS WHO ARE DEPENDENT, NEGLECTED OR DELINQUENT CHILDREN THAT WOULD OTHERWISE BE THE GOVERNMENT'S RESPONSIBILITY TO PROVIDE? | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

IF THE RESPONSE TO ANY OF THE ABOVE THREE QUESTIONS IS YES, ANSWER THE FOLLOWING QUESTIONS. OTHERWISE, SKIP TO THE NEXT PART. DO ANY OF THE FOLLOWING STATUTES OR REGULATIONS GOVERN THE INSTITUTION'S ABILITY TO RETAIN REVENUE OVER EXPENSES OR VOLUNTARY CONTRIBUTION:

- | | | | | | |
|-----|---|--------------------------|-----|--------------------------|----|
| (A) | SECTION 1315(C) AND 1905(D) OF THE SOCIAL SECURITY ACT. | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (B) | 42 CFR 440.150 (RELATING TO INTERMEDIATE CARE FACILITY SERVICES) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (C) | 42 CFR PT 483 SUBPART I (RELATING TO CONDITIONS OF PARTICIPATION FOR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (D) | THE ACT OF OCTOBER 20, 1966 (MENTAL HEALTH AND MENTAL RETARDATION ACT OF 1966) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (E) | ARTICLES II, VII, IX AND X OF THE ACT OF JUNE 13, 1967 KNOWN AS THE PUBLIC WELFARE CODE | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (F) | 23 PA.C.S. CH. 63 (RELATING TO CHILD PROTECTIVE SERVICES) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (G) | 42 PA.C.S. CH. 63 (RELATING TO JUVENILE MATTERS) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| (H) | 55 PA CODE CHS 3170 (RELATING TO ALLOWABLE COSTS AND PROCEDURES FOR COUNTY CHILDREN AND YOUTH), 3680 (RELATING TO ADMINISTRATION AND OPERATION OF A CHILDREN AND YOUTH SOCIAL SERVICE AGENCY), 4300 (RELATING TO COUNTY MENTAL HEALTH AND MENTAL RETARDATION FISCAL MANUAL), 6400 (RELATING TO COMMUNITY HOMES FOR INDIVIDUALS WITH MENTAL RETARDATION), 6500 (RELATING TO FAMILY LIVING HOMES), 6210 (RELATING TO PARTICIPATION REQUIREMENTS FOR THE INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED PROGRAM), 6211 (RELATING TO ALLOWABLE COST REIMBURSEMENT FOR NON-STATE OPERATED INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED), AND 6600 (RELATING TO INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED) | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

PART 3 - GOODS OR SERVICES PROVIDED

(1) WHAT IS THE COST OF ALL GOODS OR SERVICES PROVIDED BY THE INSTITUTION FOR WHICH IT HAS NOT RECEIVED MONETARY COMPENSATION? THIS FIGURE SHOULD NOT INCLUDE BAD DEBTS OR ACCOUNTS REPORTED AS UNCOLLECTIBLE.

(2) IF THE INSTITUTION RECEIVES A LESSER FEE THAN THE FULL COST ASSOCIATED WITH PROVIDING GOODS OR SERVICES, INDICATE WHAT THE DIFFERENCE BETWEEN THE FULL COST AND THE AMOUNT RECEIVED AS COMPENSATION.

(3) IF THE INSTITUTION CHARGES A FEE TO INDIVIDUALS PURCHASING ITS GOODS OR SERVICES, WHAT IS THE COST FOR THOSE GOODS OR SERVICES RENDERED TO INDIVIDUALS WHOSE ACCOUNTS ARE DEEMED UNCOLLECTIBLE?

(4)	DOES THE INSTITUTION HAVE A PUBLISHED <u>WRITTEN</u> POLICY STATING THAT GOODS OR SERVICES WILL BE PROVIDED TO ALL WHO SEEK THEM WITHOUT REGARD TO THEIR ABILITY TO PAY?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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(5)	DOES THE INSTITUTION HAVE A <u>WRITTEN</u> POLICY STATING THAT GOODS OR SERVICES WILL BE PROVIDED FOR A FEE BASED UPON THE RECIPIENT'S ABILITY TO PAY FOR THEM?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
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APPLICATION FOR SALES TAX EXEMPTION

- (6) DOES THE INSTITUTION HAVE A WRITTEN SCHEDULE OF FEES BASED ON INDIVIDUAL OR FAMILY INCOME? ☐ YES ☐ NO
- (7) ARE THE GOODS OR SERVICES PROVIDED FOR FREE OR AT A REDUCED PRICE OF COMPARABLE QUALITY AND QUANTITY TO THE GOODS OR SERVICES PROVIDED TO THOSE INDIVIDUALS WHO PAY A FEE GREATER THAN THE COST OF THE GOODS OR SERVICES? ☐ YES ☐ NO
- (8) WHAT IS THE INSTITUTION'S COST OF PROVIDING GOODS OR SERVICES TO RECIPIENTS OF GOVERNMENT PROGRAMS, INCLUDING MEDICARE AND MEDICAID? _____
- (9) DOES THE INSTITUTION PROVIDE GOODS OR SERVICES FOR FREE OR AT A REDUCED RATE TO GOVERNMENT AGENCIES? ☐ YES ☐ NO
- (10) DOES THE INSTITUTION PROVIDE GOODS OR SERVICES TO INDIVIDUALS ELIGIBLE FOR GOVERNMENT PROGRAMS? ☐ YES ☐ NO
- (11) WHAT IS THE INSTITUTION'S COST OF PROVIDING GOODS OR SERVICES TO INDIVIDUALS FOR WHOM THE INSTITUTION RECEIVES FEE-FOR-SERVICES PAYMENTS? _____
- (12) IS THE INSTITUTION LICENSED BY THE DEPARTMENT OF HEALTH OR THE DEPARTMENT OF PUBLIC WELFARE? ☐ YES ☐ NO
- (13) ATTACH A LISTING OF INSTITUTIONS AND THE REASONABLE VALUE OF THE CONTRIBUTION DONATED TO EACH INSTITUTION OF PURELY PUBLIC CHARITY OR A GOVERNMENTAL AGENCY.
- (14) ATTACH A LIST BY INSTITUTION OF THE REASONABLE VALUE OF ALL CONTRIBUTIONS RECEIVED BY YOUR ORGANIZATION FROM ANOTHER INSTITUTION OF PURELY PUBLIC CHARITY.

PART 4 - FUNDRAISING ACTIVITIES

- (1) DOES THE INSTITUTION CONTRIBUTE A SUBSTANTIAL PORTION OF FUNDS RAISED ON BEHALF OF, OR SUPPLY GRANTS TO, AN ORGANIZATION THAT IS RECOGNIZED AS AN INSTITUTION OF PURELY PUBLIC CHARITY, A RELIGIOUS ORGANIZATION, OR A GOVERNMENTAL AGENCY? ☐ YES ☐ NO

ATTACH TO THE APPLICATION A LISTING OF THE NAMES OF ORGANIZATIONS WHO RECEIVE THE CONTRIBUTIONS AND THE AMOUNT OF EACH CONTRIBUTION.

AUTHORIZED SIGNATURE

I, (WE) THE UNDERSIGNED, DECLARE UNDER THE PENALTIES OF PERJURY THAT THE STATEMENTS CONTAINED HEREIN ARE TRUE, CORRECT, AND COMPLETE.

SIGNATURE OF CORPORATE OFFICER

TITLE

TYPE OR PRINT NAME

DAYTIME TELEPHONE NUMBER

DATE

PREPARER'S NAME - TYPE OR PRINT

DATE

DAYTIME TELEPHONE NUMBER

TITLE

MAIL COMPLETED APPLICATION TO:

PA DEPARTMENT OF REVENUE
BUREAU OF BUSINESS TRUST FUND TAXES
MISCELLANEOUS TAX DIVISION
PO BOX 280909
HARRISBURG, PA 17128-0909
(717) 783-5473
TT# 1-800-447-3020 (Services for taxpayers
with special hearing and/or speaking needs).