



**INSTRUCTIONS FOR COMPLETING THE APPLICATION
FOR REFUND OF PROVINCIAL SALES TAX (PST)
PAID ON CHARITY-FUNDED PURCHASES
OF MEDICAL EQUIPMENT**
under the *Provincial Sales Tax Act*
FOR PST PAID AFTER MARCH 31, 2013

GENERAL INFORMATION

Complete this form to apply for a refund of provincial sales tax (PST) paid on qualifying medical equipment if you are an eligible charity. An **eligible charity** is a registered charity or a member of the British Columbia Association of Health Care Auxiliaries (BCAHA). The medical equipment must have been purchased **after March 31, 2013** using charity funds.

For detailed information on qualifying medical equipment, calculating a refund and who may apply, see **Bulletin PST 402, PST Refunds on Charity-Funded Purchases of Medical Equipment**.

Please follow the instructions carefully as your application will be returned to you for revision if:

- the form is incomplete,
- the required documents are not provided (refer to the Checklist of Requirements on **Page 2**), or
- you have claimed an excessive number of ineligible items.

After you have revised your application, you can reapply with the completed application and required documents.

An application for refund must be received by the ministry within four years from the date tax was paid. The ministry cannot issue a refund of less than \$10.

Generally, an eligible charity may only make a claim **once per calendar year**.

COMPLETING YOUR APPLICATION

Part A – Applicant Information

Item 1

Enter the current full legal name of the registered charity or member of the BCAHA that provided the charity funds for the purchase of the medical equipment.

Item 3

If applicable, a cheque and/or a refund decision letter will be mailed to this address. This address must not be the address of a third party representative, such as an external accountant, bookkeeper or consultant.

Item 4

Enter the name and telephone number of a person to contact if the ministry has questions about your application.

Part D – Refund Information

Item 5

If you have more than one refund claim schedule, enter the total amount of Column E from all refund claim schedules. If an amount is not entered, your application will be returned.

Item 6

Generally, the from/to dates of your claim period are the dates of your first and last transactions for which you are claiming a refund.

Part E – Refund Claim Schedule

Item 7

Each application must include a detailed listing of all items for which you are claiming a refund. Complete the *Refund Claim Schedule* template available in **Excel**.

Note: In Column A, include only the purchase price of eligible medical equipment, excluding taxes. In Column B, include only the PST amount paid on that eligible medical equipment.

Item 8

Medical Equipment Certification (located on the Refund Claim Schedule in Excel)

The certification must be completed by:

- an administrator of the health facility, if you directly purchase medical equipment with charity funds for use in a health facility, or
- an administrator of the health facility, if you contribute charity funds towards the purchase of medical equipment to a health facility where the equipment will be used, or
- an administrator of the health authority, if you contribute charity funds towards the purchase of medical equipment to a health authority that purchases the equipment. The equipment must be used in a health facility operated by that health authority.

A single *Refund Claim Schedule* is sufficient if any of the following situations apply to you for the medical equipment included in your refund claim:

1. You directly purchase with charity funds medical equipment for use in a single health facility, or
2. You contribute charity funds towards the purchase of medical equipment to a single health authority for use in one or more facilities operated by that health authority, or
3. You contribute charity funds towards the purchase of medical equipment to a single health facility for use in that facility.

In all other situations, more than one *Refund Claim Schedule* is required.

A health authority may only sign a certification for medical equipment the health authority purchases. Therefore, a *Refund Claim Schedule*, certified in **Item 8** by an administrator of a health authority, may only list medical equipment that health authority purchases.

Part F – Applicant Certification

Item 9

This application must be signed by an officer of the eligible charity.

Your application will be returned to you if the application is not signed, is not signed by a signing authority or is signed by a third party (external accountant, bookkeeper or consultant).

SENDING IN YOUR APPLICATION

Your application and attached documents (do **not** use staples) can be mailed or couriered to:

Mailing Address

Ministry of Finance
Consumer Taxation Programs Branch
PO Box 9628 Stn Prov Govt
Victoria BC V8W 9N6

Courier

Ministry of Finance
Refunds Section
Consumer Taxation Programs Branch
1802 Douglas Street
Victoria BC V8T 4K6

Please keep a copy of this application and supporting documents for your records.

NEED MORE INFO?

Online: gov.bc.ca/pst

Toll-free in Canada: 1 877 388-4440

Email: CTBTaxQuestions@gov.bc.ca

CHECKLIST OF REQUIREMENTS

Reference Item
on Form

- | | |
|---|--------------|
| <input type="checkbox"/> Application is in the full legal name of the eligible charity. | 1 |
| <input type="checkbox"/> Registration numbers are completed, if applicable. | 2 |
| <input type="checkbox"/> Address is the complete mailing address of the applicant. | 3 |
| <input type="checkbox"/> Total refund amount is provided. | 5 |
| <input type="checkbox"/> Claim period is provided. | 6 |
| <input type="checkbox"/> <i>Refund Claim Schedule</i> is completed and enclosed. | Excel |
| <input type="checkbox"/> Item 8 is signed by an administrator of the Health Authority or Health Facility. | Excel |
| <input type="checkbox"/> Copies of all invoices, receipts and/or bills of sale are enclosed. | 7 |
| <input type="checkbox"/> Proof of funding is enclosed. | 7 |
| <input type="checkbox"/> Part F is signed by an officer of the eligible charity. | 9 |

CONTINUE TO PAGE 3 ➔

**APPLICATION FOR REFUND OF
PROVINCIAL SALES TAX (PST)
PAID ON CHARITY-FUNDED PURCHASES
OF MEDICAL EQUIPMENT**under the *Provincial Sales Tax Act***FOR PST PAID AFTER MARCH 31, 2013****INSTRUCTIONS:**

- Complete this form to apply for a refund of PST paid on charity-funded purchases of medical equipment under the *Provincial Sales Tax Act*.
- Carefully read the instructions on **Pages 1 and 2**. Incomplete applications will be returned.
- For information on charity-funded purchases of medical equipment, see **Bulletin PST 402, PST Refunds of Charity-Funded Purchases of Medical Equipment**.
- If you require additional information, call us toll-free at 1 877 388-4440.

Freedom of Information and Protection of Privacy Act (FOIPPA)

The personal information on this form is collected for the purpose of administering the *Provincial Sales Tax Act* under the authority of section 26(a) of the FOIPPA. Questions about the collection or use of this information can be directed to the Manager, Program Services, PO Box 9442 Stn Prov Govt, Victoria BC V8W 9V4 (telephone: toll-free at 1 877 388-4440).

PART A – APPLICANT INFORMATION**1** FULL LEGAL NAME OF REGISTERED CHARITY OR MEMBER OF BRITISH COLUMBIA ASSOCIATION OF HEALTH CARE AUXILIARIES (BCAHA)**2** Check (✓) all that apply and enter your registration number(s) below:☐

REGISTERED CHARITY

CANADA REVENUE AGENCY (CRA)
REGISTRATION NUMBER _____☐

REGISTERED FOR PST

PST NUMBER _____

☐

MEMBER OF BCAHA

PST –**3** MAILING ADDRESS (include street or PO box)

CITY

PROVINCE

POSTAL CODE

4 CONTACT NAME

CONTACT TELEPHONE NUMBER

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PART B – AUTHORIZATION OF A THIRD PARTY REPRESENTATIVE

Complete this section if you authorize the ministry to discuss your refund application with a third party representative (such as an external accountant, bookkeeper or consultant).

NAME OF REPRESENTATIVE (individual and/or firm)

TELEPHONE NUMBER

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PART C – EMAIL AUTHORIZATION

If you authorize the ministry to communicate with you or your third party representative by email, enter the email address below. Although we will take reasonable steps to protect all information once received, we cannot guarantee the absolute safety of personal information during transmission by email.

APPLICANT CONTACT EMAIL ADDRESS

REPRESENTATIVE EMAIL ADDRESS

PART D – REFUND INFORMATION**5** TOTAL AMOUNT OF YOUR PST REFUND CLAIM

\$

6

Claim Period

FROM
YYYY / MM / DDTO
YYYY / MM / DD**PART E – REFUND CLAIM SCHEDULE****7** Please include:

- **Refund claim schedule** – Complete the *Refund Claim Schedule* template, available in **Excel**. The medical equipment certification must be completed (Item 8 on the Excel template).
- **Invoices, receipts, bills of sale** – Enclose legible copies of all invoices, receipts and/or bills of sale (do **not** use staples).
- **Proof of funding** – Enclose proof of funding confirmations by the eligible charity to the Health Authority or Health Facility.

For more information, see the Instructions on **Page 1**.

PART F – APPLICANT CERTIFICATION (MUST be completed by an officer of the eligible charity)**9**

I certify:

- that the medical equipment claimed in this application was purchased with charity funds of the eligible charity in the amount indicated,
- that the information given in this application is, to the best of my knowledge, accurate and complete,
- the medical equipment listed in this application has not been previously claimed, and
- I am authorized to sign on behalf of the eligible charity.

I authorize the ministry to discuss the contents of this application with any Health Authority or Health Facility referenced in this application.

I understand that false statements may result in tax assessments, fines and/or penalties.

☐

I authorize the Ministry of Finance to exchange information with me using electronic media such as CDs or DVDs.

SIGNATURE OF OFFICER OR MEMBER

NAME OF OFFICER OR MEMBER

TITLE OF OFFICER OR MEMBER

DATE SIGNED
YYYY / MM / DD**X**

CONTACT TELEPHONE NUMBER

CONTACT EMAIL ADDRESS

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