BRITISH COLUMBIA | Ministry of Finance

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

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 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.

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 us within four years from the date tax was paid. We 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 we have 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 Excel template** available on our website.

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 Excel template)

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,
- 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,
- 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,
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,
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 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).

SUBMITTING YOUR APPLICATION

Do not submit original documents with your application. Ensure copies are legible.

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

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

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

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

AFTER YOU APPLY

When reviewing your claim, we may ask you to provide additional supporting documentation, including proof of payment.

Note: Electronic Funds Transfer documents and third-party payment system documents must show the name of the payee.

If you do not provide additional supporting documentation or proof of payment on request, your refund request may be disallowed.

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

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BRITISH COLUMBIA | Ministry of Finance

Mailing Address:
PO Box 9628 Stn Prov Govt
Victoria BC V8W 9N6
gov.bc.ca/pst

APPLICATION FOR REFUND OF PROVINCIAL SALES TAX (PST) PAID ON CHARITY-FUNDED PURCHASES OF MEDICAL EQUIPMENT

under the Provincial Sales Tax Act

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 Director, Policy, Rulings and 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

☐ MEMBER OF BCAHA

☐ REGISTERED FOR PST — PST NUMBER **PST –**

3 MAILING ADDRESS (include street or PO box)	CITY	PROVINCE	POSTAL CODE

4 CONTACT NAME	CONTACT TELEPHONE NUMBER

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

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 / DD	TO YYYY / MM / DD
$			

PART E – REFUND CLAIM SCHEDULE

7 Please include:

- **Refund claim schedule** – Complete the **Refund Claim Schedule Excel template** available on our website. 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**.

CONTINUE TO **PAGE 4** ➡

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,
- 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 certify that the information I have provided is true and complete. I acknowledge that providing false or incomplete information may result in penalties, fines and/or imprisonment.

☐ **I authorize the Ministry of Finance to exchange information with me using electronic media such as a USB flash drive.**

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		

Print Form Clear Form