

Township of Lower Merion  
Department of Finance – LST Collector  
75 E. Lancaster Avenue  
Ardmore, PA 19003  
Phone: 610-645-6142 FAX: 610-649-2529  
www.lowermerion.org

## **APPLICATION FOR REFUND OF LOCAL SERVICES TAX (LST) AND/OR EMERGENCY AND MUNICIPAL SERVICES TAX (EMST)**

- A copy of this APPLICATION FOR REFUND OF THE LST AND/OR EMST and all necessary supporting documents must be completed and presented to the office above.
- This application for refund of L ST And/ Or EMST must be signed and dated.
- **No refund will be approved until proper documentation has been received. Incomplete applications will be returned.**

Name: \_\_\_\_\_ Soc Sec #: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #: \_\_\_\_\_  
City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

Amount of refund requested: \$ \_\_\_\_\_ (MUST be more than \$1)

### **REASON FOR REFUND – CHECK ALL THAT APPLY**

1. \_\_\_\_\_ **I had LST/EMST tax withheld by multiple employers:** (Please attach a copy of a current pay statement from your principal employer that shows the name of the employer, the length of the payroll period and the amount of LST/EMST withheld. List all employers on the reverse side of this form).
2. \_\_\_\_\_ **My total earned income (including tips) and net profits from all sources within the Township of Lower Merion was less than \$12,000 for the tax year.** (Please attach a copy of your final pay statements from all employers within the Township of Lower Merion for the tax year for which you are requesting a refund of LST/EMST. If you are self-employed, attach a copy of your PA Schedule C, F or RK-1 for the year for which you are requesting to receive a refund of the LST/EMST).
3. \_\_\_\_\_ **I am on active military duty.** (LST ONLY - Please attach a copy of your orders directing you to active duty status).
4. \_\_\_\_\_ **I am a veteran with a qualifying disability.** (LST ONLY - Please attach copy of your discharge orders and a statement from the United States Veterans Administration declaring your disability to be a total one hundred percent permanent disability).

**I DECLARE UNDER PENALTY OF LAW THAT THE INFORMATION STATED ON AND ATTACHED TO THIS FORM IS TRUE AND CORRECT:**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_  
PRINT NAME: \_\_\_\_\_

SIGN HERE AND COMPLETE EMPLOYER LIST ON REVERSE

**Employment Information:** List all places of employment for the applicable tax year. Please list your **PRIMARY EMPLOYER** under #1 below and your other employers under the other columns. If self employed, write SELF as the Employer's Name.

	<b>1. (Primary Employer)</b>	<b>Employer 2.</b>	<b>Employer 3</b>
Employer's Name			
Address			
Address 2			
City, State, Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

	<b>Employer 4</b>	<b>Employer 5</b>	<b>Employer 6</b>
Employer's Name			
Address			
Address 2			
City, State, Zip			
Municipality			
Phone			
Start Date			
End Date			
Status (FT or PT)			
Gross Earnings			

**PLEASE NOTE:**

All information received by the Tax Collector is considered to be **CONFIDENTIAL** and is only used for official purposes relating to the collection, administration and enforcement of the LST/EMST.