



# Town of Loxahatchee Groves

155 F Road • Loxahatchee Groves, Florida 33470 •

(561) 793-2418 Phone • (561) 793-2420 • loxahatcheegrovesfl.gov

## LOCAL BUSINESS TAX RECEIPT (BTR) FEE EXEMPTION REQUEST

Name of Applicant: \_\_\_\_\_

Name of Business/Organization/Entity: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Local BTR #: \_\_\_\_\_

Federal Employer Identification Number (FEIN): \_\_\_\_\_

or Social Security Number: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title/Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

Email: \_\_\_\_\_

I, the Applicant, do hereby attest, under penalty of perjury, that I (check one):

- am a veteran of the United States Armed Forces who has been honorably discharged, or the spouse or remarried surviving spouse of such a veteran;
- am the spouse of an active duty military servicemember who has relocated to the Town of Loxahatchee Groves pursuant to a permanent change of station order;
- am a person who is receiving public assistance as defined in Section 409.2554, Florida Statutes; or
- am a person whose household income is below 130 percent of the federal poverty level based on the current year's federal poverty guidelines;

AND (check one):

- own a majority interest in the Business and the Business has fewer than 100 employees; or
- this section is not applicable to me.

OR

- we are a charitable, religious, fraternal, youth, civic, service, or other similar organization that makes occasional sales or engages in fundraising projects that are performed exclusively by the members, and the proceeds derived from the activities are used exclusively in the charitable, religious, fraternal, youth, civic, and service activities of the organization.



# Town of Loxahatchee Groves

155 F Road • Loxahatchee Groves, Florida 33470 •

(561) 793-2418 Phone • (561) 793-2420 • loxahatcheegrovesfl.gov

am a disabled person physically incapable of manual labor, a widow with minor dependents, or 65 years of age or older; and

- have not more than one (1) employee or helper;
- use my own capital only (not in excess of \$1,000); and
- am a resident of the Town of Loxahatchee Groves.

**And, with this request, I am providing written documentation in support of my request to the Town of Loxahatchee Groves (i.e. discharge papers, proof of income, Sunbiz reports, physician certification\*). I understand that this request will not be processed without supporting documentation being provided.**

\*Sample Form for Physician Certification is attached hereto as Exhibit "A".

I further attest that if granted, this exemption will only be used in the manner authorized under the provisions of Chapter 205, Florida Statutes, and I understand that this exemption does not apply to any amount required by law for the issuance of a license to sell intoxicating liquors or malt and vinous beverages.

Applicant:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Print Name

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

Sworn to (or affirmed) and subscribed before me by means of [ ] physical presence or [ ] online notarization, this \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, by \_\_\_\_\_, who is [ ] personally known to me or [ ] produced \_\_\_\_\_ as identification.

\_\_\_\_\_  
(Signature of Notary Public-State of Florida)

\_\_\_\_\_  
(Print, type, or stamp commissioned name of Notary public)



# Town of Loxahatchee Groves

155 F Road • Loxahatchee Groves, Florida 33470 •

(561) 793-2418 Phone • (561) 793-2420 • loxahatcheegrovesfl.gov

## Exhibit "A"

### PHYSICIAN CERTIFICATION FOR DISABLED PERSONS

STATE OF \_\_\_\_\_)

COUNTY OF \_\_\_\_\_)

I, \_\_\_\_\_, hereby certify that I am a licensed practicing physician, located at \_\_\_\_\_, Florida, and I am personally acquainted with \_\_\_\_\_ ("Applicant") who is an applicant for the exemption from payment of business tax under the provisions of Chapter 205, Florida Statutes, and that on \_\_\_\_\_ I have thoroughly examined the Applicant and found him or her to be physically disabled. The nature and extent of the Applicant's disability are as follows:

---

---

---

---

Address:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone No.: \_\_\_\_\_

\_\_\_\_\_  
Print Name

Date: \_\_\_\_\_