

# Low Income Taxpayer Clinics (LITCs) Application Information

## Grant Period Request *(Check one)*

- Single year request  
 Multi-year request     1st of 3 years     2nd of 3 years     3rd of 3 years

## Grant Amount Requested

Controversy     ESL     Total

## Applicant Information

Legal name of sponsoring organization

Prefix     First Name     Middle Name

Last Name     Suffix

Title     Phone number     Fax number

Email address

## Applicant's Mailing Address

Street

Street address line 2

City     State

ZIP + 4 code

## Clinic Information

Name of clinic

Public telephone number     Toll-Free telephone number *(if applicable)*

Website address *(if applicable)*     Fax number

Languages served in addition to English

## Clinic Street Address

Street     City

State     ZIP + 4 code

**Clinic Mailing Address**

Street	City
[Redacted]	[Redacted]
State	ZIP + 4 code
[Redacted]	[Redacted]

**Clinic Director Information**

Prefix	First Name	Middle Name
	[Redacted]	
Last Name	Suffix	
[Redacted]		
Telephone number	Email address	
[Redacted]	[Redacted]	
Licenses/Certifications ( <i>Check all that apply</i> )		
<input type="checkbox"/> Attorney <input type="checkbox"/> CPA <input type="checkbox"/> Enrolled Agent <input type="checkbox"/> Other		

**Qualified Tax Expert (QTE)**

Prefix	First Name	Middle Name
	[Redacted]	
Last Name	Suffix	
[Redacted]		
Telephone number	Email address	
[Redacted]	[Redacted]	
Licenses/Certifications ( <i>Check all that apply</i> )		
<input type="checkbox"/> Attorney <input type="checkbox"/> CPA <input type="checkbox"/> Enrolled Agent <input type="checkbox"/> Other		

**Qualified Business Administrator (QBA)**

Prefix	First Name	Middle Name
	[Redacted]	
Last Name	Suffix	
[Redacted]		
Telephone number	Email address	
[Redacted]	[Redacted]	