Tax Questionnaire

Your Name: ____
First Middle Last Suffix
____
Social Security Number Date of Birth Occupation
____ Employed ____ Self-Employed ____ Homemaker ____ Retired ____ Unemployed
Under disability? ____ Yes ____ No If yes, please attach Social Services, physician or program documentation.

Spouse/
Partner: ____
First Middle Last Suffix
____
Social Security Number Date of Birth Occupation
____ Employed ____ Self-Employed ____ Homemaker ____ Retired ____ Unemployed
Under disability? ____ Yes ____ No If yes, please attach Social Services, physician or program documentation.

Address: ____
Mailing Address
____
If your street address is different, please list it here
____
Telephone Number E-Mail Address

Please attach or provide photo identification for yourself and spouse/partner.

Relationship Status: ____ Married ____ Single ____ Divorced ____ Separated ____ Widowed ____ Other
If other, please explain ____

Are you receiving any supplemental benefits? ____ SSI ____ SNAP ____ Medicaid ____ Medicare ____ CHIP ____ WIC ____ Other (please explain)____

Do you have minor/dependent children? ____ Yes ____ No If yes, please complete the following:

Name ____ SSN _________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Name ____ SSN _________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Name ____ SSN _________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Name ____ SSN _________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Name ____ SSN _________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No

You must attach proof your child(ren) can be claimed as a dependent. Please attach a copy of the child’s birth certificate, Social Security Card, divorce decree, or other documentation.

You must also attach proof your child(ren) reside with you. Please attach a letter or documentation showing your child's name and residence address from a school, landlord, physician, child care provider, Social Services agency, house of worship or clergy, or employer.

Do you have other dependents? ___ Yes ___ No If yes, please complete the following:

Name ____ SSN __________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Relationship to you ____

Name ____ SSN __________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Relationship to you ____

Name ____ SSN __________________ DOB ___________
Disabled ____ Yes ____ No (attach Social Services or physician determination)
Child Care ____ Yes ____ No
Relationship to you ____

You must attach proof of dependency and residence.

Do you have any unpaid taxes from prior years? ____ Yes ____ No If yes, please explain ________________
____

Did you relocate last year? ____ Yes ____ No If yes, please explain ___________________________________
____

Did a member of your household die last year? ____ Yes ____ No If yes, please provide the name, relationship and date of death: ____

Did you have health insurance last year? ____ Yes ____ No If yes, attach all Forms 1095.

Name of Company ____
Is everyone in your household covered under the same policy? ____ Yes ____ No
Amount of your monthly premium $_____
Was everyone in your household covered from January 1st to December 31st? ____ Yes ____ No
If no, please explain: ____
Did you receive premium tax credits? ____ Yes ____ No

Do you believe you are exempt from the health insurance requirement? ____ Yes ____ No If yes, please complete the following:

Do you have an Exemption Certificate Number? ____ Yes ____ No If yes, please a copy of the letter/notice granting the exemption.
Are you a member of a health care sharing ministry? ____ Yes ____ No If yes, please provide your most recent statement and documentation showing who in your household is covered.
Were you incarcerated during the past year? ____ Yes ____ No
Are you a member of an Indian Tribe? ____ Yes ____ No
Are you eligible for Medicaid? ____ Yes ____ No If no and your income is below the cut-off for Medicaid eligibility, please provide Social Services denial letter or explain your answer ____________
____

Income

Did you earn wages from employment? ____ Yes ____ No If yes, attach all W-2s and Forms 1099-MISC or list of income/receipts if you did not receive a 1099.
Did you receive interest and/or dividends? ____ Yes ____ No If yes, attach all Forms 1099 you received.
Did you receive Social Security retirement benefits? ____ Yes ____ No If yes, attach SSA-1099 and/or annual Social Security statement
Did you receive pension/IRA distributions? ____ Yes ____ No If yes, attach all Forms 1099.
Did you receive any rents, royalties or distributions? ____ Yes ____ No If yes, attach all Forms 1099 and other statements received
Did you receive unemployment compensation, state tax refund or other income? ____ Yes ____ No Please attach supporting statements or information.
Did anyone in your household receive a scholarship last year? ____ Yes ____ No If yes, please attach statements.
Did you sell any assets for capital gain or loss (investments, real estate, collectibles or other assets)? ____ Yes ____ No If yes, please attach statements.

Deductions, Expenses and Credits

Do you own your residence? ___ Yes ___ No If yes, is there a mortgage? ___ Yes ___ No Please attach Form 1098 if you wish to deduct mortgage interest.
Amount of real estate tax paid $_________ Amount of PMI paid $__________
Are you self-employed? ___ Yes ___ No If yes, please attach a record of related expenses.
Did you pay for child care last year? ____ Yes ____ No If yes, please attach evidence of payment.
Did you pay tuition for higher education for anyone in the household? ____ Yes ____ No If yes, please attach a record of expenses or tax form reporting education payments.
Did you pay for health care, medical expenses or prescription drugs; transportation to obtain health care; or hearing aids, eyeglasses or other medical devices? ____ Yes ____ No If yes, please estimate the total amount ($____________). You may be requested to provide statements or paid receipts evidencing payment.
Did you pay on any student loans? ____ Yes ____ No If yes, please attach evidence of interest payments.
Did you make charitable contributions last year? ____ Yes ____ No If yes, please provide receipts or evidence of payment.
Did you have any casualty or theft losses last year? ____ Yes ____ No If yes, you may be asked to provide evidence of payment.
Did you contribute to any retirement accounts last year? ____ Yes ____ No If yes, please attach statements or tax forms.