Checklist

Name: HUSBAND & WIFE TEST SSN: ***-**-1005

Checklist

This check list is provided to help you gather necessary information for us to prepare your 2018 income tax return. Return this list, along with the supporting documentation, to our office and let us know of any significant changes from your 2017 tax year.

Health Care Coverage (for each member of the household)

- [ ] Health Insurance Statements (Forms 1095-A, 1095-B, 1095-C)
- [ ] Any exemption certificates received from HHS giving you an exemption from having health insurance

Other Income (provide supporting documentation for income received for the following items)

- [ ] Sale of assets or property
- [ ] Cancellation of debt
- [ ] Other income _____

Payments (provide supporting documentation for payments made for the following items)

- [ ] Educator classroom expenses
- [ ] Employee business expenses
- [ ] Contributions to a Health Savings Account
- [ ] Expenses related to work relocation
- [ ] Alimony
- [ ] Student loan interest
- [ ] Tuition and fees for higher education
- [ ] Expenses related to child or dependent care
- [ ] Contributions to a Retirement Savings Account
- [ ] Medical and dental expenses
- [ ] Real estate taxes
- [ ] Other state and local taxes
- [ ] Mortgage interest
- [ ] Investment interest
- [ ] Cash Contributions
- [ ] Noncash Contributions
- [ ] Unreimbursed employee expenses
- [ ] Investment expenses
- [ ] Gambling losses
- [ ] Other payments _____

2018 Summary Organizer
Personal and Dependent Information

Personal Information

	Name	SSN	Date of birth	Healthcare coverage ALL year
Taxpayer	HUSBAND TEST	***-**-1005	01-01-1965	
Spouse	WIFE TEST		01-01-1966	

Street address, city, state, and ZIP
10 YOUR ROAD PAOLI PA 19301

	Occupation	Daytime phone	Evening phone	Cell phone
Taxpayer	TEST TAKER			
Spouse	TEST GIVER			

Taxpayer email	
Spouse email	

Marital Status at end of 2018

- ☐ Married
- ☐ Married filing separately
- ☐ Single
- ☐ Widow(er) If spouse died in 2018 enter the date of death _____

	Taxpayer		Spouse	
Are you blind?	☐ Yes	☐ No	☐ Yes	☐ No
Are you disabled?	☐ Yes	☐ No	☐ Yes	☐ No
Are you a full-time student?	☐ Yes	☐ No	☐ Yes	☐ No
Do you want $3 to go to the Presidential Election Campaign Fund?	☐ Yes	☐ No	☐ Yes	☐ No

Dependent Information

First and last name	SSN	Relationship	Months in home	Date of birth	Disabled	Full-time student	Healthcare coverage ALL year

List dependents required to file a return _____

Estimates

	Federal		Resident state		Resident city	
	Date paid	Amount	Date paid	Amount	Date paid	Amount
Overpayment applied from 2017						
First quarter						
Second quarter						
Third quarter						
Fourth quarter						
Additional payments						

Account Information for Deposits or Withdrawals

Name of bank	Bank routing number	Bank account number	Type of account		Use this account for	
			Checking	Savings	Deposits	Withdrawals

Appointment Information

Your 2018 appointment is scheduled for _____

Healthcare Coverage Questionnaire

Name: HUSBAND & WIFE TEST SSN: ***-**-1005

Healthcare Information

Member of household for healthcare purposes	Covered the entire year	Covered less than 12 months	No healthcare coverage at all
HUSBAND			
WIFE			

YES **NO**

☐ ☐ Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?

☐ ☐ Did you pay for healthcare coverage for anyone not listed above?

If you had coverage for any part of the year:

Where was the policy obtained?

Employer / Medicare / Medicaid / Marketplace(Exchange) / Other

If you didn't have coverage part or all of the year:

Answer YES if the following applies to any member of the household

☐ ☐ Was your previous insurance policy canceled in 2018?

☐ ☐ Was coverage offered by your employer or your spouse's employer?

☐ ☐ Are you a member of a federally recognized Indian tribe?

☐ ☐ Are you eligible for services through an Indian healthcare provider?

☐ ☐ Are you a member of a healthcare sharing ministry?

☐ ☐ Did you live in the United States the entire year?

☐ ☐ Are you enrolled in TRICARE?

☐ ☐ Did you apply for CHIP coverage?

☐ ☐ Do any of the following apply to you? Do NOT indicate which one.

- Became homeless
- Evicted in the past six months, or facing eviction or foreclosure
- Received a shut-off notice from a utility company
- Recently experienced domestic violence
- Recently experienced the death of a close family member
- Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
- Filed for bankruptcy in the last six months
- Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
- Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member