MANDATORY ACA QUESTIONNAIRE -2015 TAX YEAR

This questionnaire **MUST BE COMPLETED AND SIGNED** on the reverse side and submitted with your tax return documents **BEFORE** we will begin to prepare your return

PRIMARY TAXPAYER

Did you have qualifying health insurance coverage ALL 12 months of 2015? (More than 1 box may apply)

- ☐ Yes, through the Exchange/Marketplace---must provide Form 1095-A
  If yes, did you receive an Advance Premium Tax Credit ☐ Yes ☐ No
- ☐ Yes, from **Medicare/Medicaid**
- ☐ Yes, from **my employer**
- ☐ Yes, from **individual policy**
- ☐ No, I did not have coverage **for any months** of 2015---Are you a tobacco user? ☐ Yes ☐ No
- ☐ No, but I did have coverage **for some months** of 2015---Are you a tobacco user? ☐ Yes ☐ No
  If you had *some* coverage, complete "Insurance Coverage Chart" on back

SPOUSE (If Married, Filing Jointly)

Did your spouse have qualifying health insurance coverage ALL 12 months of 2015?

- ☐ Not applicable (Married Filing Separately or Single)
- ☐ Yes, it is the same as primary taxpayer's coverage
- ☐ Yes, but it is different than the primary taxpayer's coverage
  If spouse insurance is *different* than taxpayer, complete "Insurance Coverage Chart" on back
- ☐ No, my spouse did not have coverage **for any months** of 2015
  Is this spouse a tobacco user? ☐ Yes ☐ No
- ☐ No, but my spouse did have coverage **for some months** of 2015
  Is this spouse a tobacco user? ☐ Yes ☐ No
  If spouse had *some* coverage, complete "Insurance Coverage Chart" on back

DEPENDENTS
(Only include those which are part of your TAX HOUSEHOLD)

Did your dependent(s) have qualifying health insurance ALL 12 months of 2015?

- ☐ Not Applicable (No Dependents)
- ☐ Yes, it is the same as primary taxpayer's coverage
- ☐ Yes, but it is different than the primary taxpayer's coverage
  If dependent's insurance is *different* than taxpayer, complete "Insurance Coverage Chart "on back
- ☐ No, my dependent(s) did not have coverage **for any months** of 2015
  Is this dependent a tobacco user? ☐ Yes ☐ No
- ☐ No, but my dependent(s) did have coverage **for some months** of 2015
  Is this dependent a tobacco user? ☐ Yes ☐ No
  If dependent had *some* coverage, complete "Insurance Coverage Chart" on back

Did any dependent in your tax household have income in 2015?

- ☐ Not Applicable (No Dependents)
- ☐ No
- ☐ Yes (If yes, mark the appropriate box below)
  - ☐ My dependent needs to file a return
    (It is highly beneficial for you to have us file the dependent's return)
  - ☐ My dependent does not typically have to file a return
    (We need to review the tax documents to be sure for 2015 before we can begin your return)
  - ☐ My dependent has already filed a return (**NOT RECOMMENDED)**
    (We need to review a copy of the filed return for 2015 before we can begin your return)

Certain income for dependents must be included in the calculation for Premium Tax Credit.
We MUST review this income before we can proceed

Exemptions

(From The Individual Shared Responsibility Payment)

Did you qualify for an exemption?

- ☐ No
- ☐ Yes (If yes, mark the appropriate box below)
  - ☐ Part of a recognized religious sect (include proof of exemption with exemption #)
  - ☐ Part of a health sharing ministry (include proof of exemption with exemption #)
  - ☐ Incarcerated (include proof)
  - ☐ Member of an Indian Tribe (include proof of exemption with exemption #)
  - ☐ Hardship Exemption (include proof of exemption with exemption #)

EXEMPTION CERTIFICATE NUMBERS

Taxpayer	
Spouse	
Dependent 1	
Dependent 2	
Dependent 3	
Dependent 4	

Insurance Coverage Chart

(Complete only if prompted from an earlier question)

Place an "X" in the box for any month with NO coverage

Individual	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Taxpayer												
Spouse												
Dependent 1												
Dependent 2												
Dependent 3												
Dependent 4												

Describe coverage for each individual in your tax household (Include Proof)

Individual	Type of Coverage	From (Exchange/employer/other)
Taxpayer		
Spouse		
Dependent 1		
Dependent 2		
Dependent 3		
Dependent 4		

If any individual had more than one type of coverage, or there are other situations we should be aware of, please attach additional pages as needed.

By signing below, I acknowledge that the Health Care information I have provided is accurate and complete.

Taxpayer Signature:_____ **Date:**_____