TAX ORGANIZER

Client Name or Names:			
Client Social Security Numbers	Primary:	Spouse:	
This past year, did you get (check one):	Married? Divorced? Widowed? If widowed, date:		
If newly married:	Spouse Name (First, Middle, Last)		
	Spouse SS#:	Spouse DOB:	
Address:			
Primary Phone (Cell, Work, Home):	Secondary Phone (Cell, Work, Home):		
Email Address:	In future years, may we send organizer by email? Yes No		

Did you add any Dependents during the past year?	Date of Birth:	Relationship:	Social Security Number:	Number of months living in your home:

Will we remove any Dependents for the past year? Name:

INCOME-Please attach the following forms:				**CONTRIBUTIONS**	**Dollar Amount**
W-2's, 1099's attached:	**Yes**	**No**	**# of Forms**	Total Church	$
Salary & Wages (W-2)				Total Charity	$
Social Security (1099-SSA)				Noncash Donations (FMV)	$
Interest (1099-INT)				(Must Itemize if over $500)	
Dividend (1099-DIV)				Name of Charity Given to:	
Stock Sales (1099-B)				Charitable Miles Driven	
Pensions (1099-R)				**MISC DEDUCTIONS**	$
Non-Employee Comp (1099-Misc)				Tax Preparation Fees	$
Unemployment Comp (1099-G)				Safe Deposit Box Rent	$
Gambling Winnings (W-2G)				Investment Fees	$
Partnership or S Corp (K-1)				Disaster or Theft	$

OTHER INCOME	**Dollar Amount**	**EMPLOYEE EXPENSES (If not reimbursed by employer)**	
Alimony Received	$	Miles Driven (Unreimbursed)	# of Miles:
Self-Owned Business Income	**Request Schedule C Organizer**	Travel Expenses	$
Rental Income	**Request Schedule E Organizer**	Meals & Entertainment	$
OTHER DEDUCTIONS		Union Dues	$
Work Related Moving Expenses	$	Uniforms (Not street clothes)	$
IRA contributions	$	Gifts to Clients	$
Alimony Paid	$	Supplies	$
MEDICAL EXPENSES (Paid out of pocket and unreimbursed by insurance)		Safety Equipment/Tools	$
Health Premium (if not deducted pre-tax on your paycheck)$		**CHILD & DEPENDENT CARE**	
Cancer Insurance Premiums	$	Child & Dependent Care Paid	$
Vision Insurance Premiums	$	Age of Child or Dependent:	
Ambulances	$	Provider Name:	
Glasses & Contact Lenses	$	Provider Federal ID or SSN:	
Hearing Aids & Batteries	$		
Dentures	$	**EDUCATION EXPENSES**	**# of Forms Attached**
Long-Term Care Premiums	$	College Tuition (1098-T)	
Medical Miles Driven	# of Miles	Student Loan Interest (1098-E)	
Prescription Drugs & Insulin	$	**Taxes Paid**	
Doctors/Dentists/Hospitals/Labs	$	Real Estate Tax	$
Questions, Comments or Notes		Ad Valorem Tax on Car Tags	$
		Mortgage Interest Paid	
		Mortgage Interest Statement	Attach From 1098
		Mortgage Int Not Reported on 1098	

Estimated Taxes Paid (Amount and Date Paid)					
1st Quarter Federal	$	Date:	1st Quarter State	$	Date:
2nd Quarter Federal	$	Date:	2nd Quarter State	$	Date:
3rd Quarter Federal	$	Date:	3rd Quarter State	$	Date:
4th Quarter Federal	$	Date:	4th Quarter State	$	Date:

Please fill out additional information questions and healthcare information on other side.

General Information:

Yes	No	
		Can you or your spouse be claimed as a dependent by someone else?
		Did you move during the past year? If yes, from where: _____Date of move :_____
		Did you receive any notices from the IRS or the state taxing agency? If yes, please attach.
		Did you start a new business during the past year? If yes, please request or download and complete a Schedule C (small business) organizer.
		Did you start renting any property during the past year? If yes, please request or download and complete a Schedule E (rental property) organizer.
		Did you use a home office during the past year? If yes, total square footage of house: _____ Square footage used as office:_____
		Did you have dependents that had earned income over $10,150 during the year? If yes, attach W-2 or 1099.
		Did you have dependents that had over $2,000 of investment income?
		Did you purchase a home between April 8 and December 31 in which the First-Time Homebuyer Credit was taken on the home?

Health Insurance – Coverage & Premium Credit

		Are all members of household covered under the same policy? If yes, provided by: Exchange/Employer
		Did all members of your household have coverage for the entire year (January 1st-December31st)?
If you answered yes to both the above questions, stop here. Include a copy of your insurance card, or if your insurance is through the Exchange, the From 1095-C you received in the mail.		

If you answered no to either of the above questions, please complete the below information:

Health Insurance – Exchange Exemptions

Yes	No	
		Was your insurance coverage cancelled by the provider during the past year?
		Did you have an exemption determined by the Exchange? If yes, attach ENC letter. (If you are not sure if you qualify for an Exchange Exemption, apply on-line at least 3 weeks before doing tax return)

	Unaffordable		**Indian Tribe**		**Member of health care sharing ministry**
	Hardship		**Incarcerated**		**Religious sect opposed to health insurance**

Health Insurance – Tax Return Exemptions

If you do not have an exemption through the Exchange, and you did not have insurance for the entire year, you may qualify for an Unaffordability or other Exemption calculated on your tax return. To determine, please provide:

If more than one policy, name of members of Household claimed on your return (Tax Payer #)	Where was their Coverage obtained? (Employer/Medicare/TriCare/Individual Plan)
1)	
2)	
3)	
4)	
5)	

Insert the premium amount for each month (if all in household on one policy, fill in "Family" line only. If separate policies, insert premium for each individual in same order as 1-5 above.

	Jan	Feb	Mar	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Family Policy												
1)												
2)												
3)												
4)												
5)												