Health Insurance Questionnaire Affordable Care Act

Taxpayer First Name	
Taxpayer Last Name	
Social Security Number	

1. Did you have health insurance for **yourself and all of your dependents** all 12 months?

   ☐ **Yes** ☐ **No** (if you answered "NO" skip to Question #5).

2. Did you receive **form 1095** from your employer, your insurance company, or HHS?

   ☐ **Yes** ☐ **No**

3. Did you receive any **Health Care Premium Credits** to assist in monthly payment for Health Insurance?

   ☐ **Yes** ☐ **No** if so, how much did you receive each month $ _____?

4. If you answered "YES" to Question #1,

   Did you purchase your health insurance through **Market Place / Healthcare.gov**? ☐ **Yes** ☐ **No**
   Did you purchase your health insurance directly from an **Insurance Agent**? ☐ **Yes** ☐ **No**
   Was your insurance provided by your **Employer**? ☐ **Yes** ☐ **No**
   Were you covered by **Medicare** or **Medicaid**? ☐ **Yes** ☐ **No**

5. If you answered "NO" to Question #1,
   Did **you or any of your dependents** have health insurance for **any part** of the year? ☐ **Yes** ☐ **No**

   If yes, what months **DIDN'T** you have coverage? (check all that apply)

   Taxpayer: ☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **Jul** ☐ **Aug** ☐ **Sep** ☐ **Oct** ☐ **Nov** ☐ **Dec**
   Spouse: ☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **Jul** ☐ **Aug** ☐ **Sep** ☐ **Oct** ☐ **Nov** ☐ **Dec**
   Dependents: ☐ **Jan** ☐ **Feb** ☐ **Mar** ☐ **Apr** ☐ **May** ☐ **Jun** ☐ **Jul** ☐ **Aug** ☐ **Sep** ☐ **Oct** ☐ **Nov** ☐ **Dec**

→ **Please continue to Page 2** →

If you answered "NO" to Question #1,

6. Do you meet any of the following criteria for exemption of Tax Penalty? (check all that apply)

- ☐ Unaffordable - lowest priced coverage available to you would cost more than 8% of your household income.
- ☐ Short coverage gap - you went less than 3 consecutive months without coverage.
- ☐ You were incarcerated (detained or in jail).
- ☐ You are not lawfully present in the U.S (not a citizen, nor a US National, are living Abroad, or a Resident of a Foreign Country).
- ☐ You are a member of a recognized health care sharing ministry.
- ☐ You are a member of a recognized religious sect (religious objections to insurance, including Social Security and Medicare).
- ☐ You are enrolled in Limited Benefit Medicaid or TRICARE or VA program.
- ☐ Your employer has a Fiscal Year Employer Health Insurance Sponsored Plan.
- ☐ You are a member of the American Indian Tribe.
- ☐ You qualify for Hardship Exemption.

7. If you answered that you **qualify for "Hardship Exemption"** to Question #6, (check all that apply)

- ☐ You were homeless.
- ☐ You were evicted in the last 6 months OR you were facing eviction or foreclosure.
- ☐ You received a shut-off notice from a utility company (anytime during the year)
- ☐ You experienced domestic violence (spouse, son, daughter, family, neighbor, etc. during the year).
- ☐ You experienced the death of a close family member in during the year.
- ☐ You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property.
- ☐ You filed for bankruptcy in the last 6 months of the year.
- ☐ You had medical expenses that you could not pay in the year that resulted in substantial debt.
- ☐ You experienced unexpected increase in necessary expenses due to caring for ill, disabled, or aging family member.
- ☐ You expect to claim a child as a tax dependent who has been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child.
- ☐ You were determined ineligible for Medicaid because your state did not expand eligibility for Medicaid under the Affordable Care Act.
- ☐ Other _____

_____

Taxpayer's Statement

Under penalties of perjury, I declare that all of the above information is true and correct and should be used in completing my tax return. I further understand that any false statement by me and/or my spouse is considered fraud and is punishable under the law of the United States Government.

Taxpayer: _____ Date: _____

Spouse: _____ Date: _____

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