

## 2016 Tax Organizer Personal and Dependent Information

### Personal Information

	Name	SSN	Date of Birth	Healthcare coverage ALL year
Taxpayer				
Spouse				
Street address, city, state, and ZIP				
	Occupation	Daytime Phone	Evening Phone	Cell Phone
Taxpayer				
Spouse				
Taxpayer Email				
Spouse Email				

#### Marital Status at end of 2016

- Married  
 Married filing separately  
 Single  
 Widow(er), Date of Spouse's Death if deceased in 2016 \_\_\_\_\_

#### Taxpayer

- Yes  No  
 Yes  No  
 Yes  No  
 Yes  No

#### Spouse

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

### 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 2015	_____	_____	_____	_____	_____	_____
First quarter	_____	_____	_____	_____	_____	_____
Second quarter	_____	_____	_____	_____	_____	_____
Third quarter	_____	_____	_____	_____	_____	_____
Fourth quarter	_____	_____	_____	_____	_____	_____
Additional payments	_____	_____	_____	_____	_____	_____

### Appointment Information & Notes

Your 2016 appointment is scheduled for \_\_\_\_\_

#### Notes

## Healthcare Coverage Questionnaire

Name:

SSN:

### Healthcare Information

Had healthcare coverage:	For the entire year	For part of the year (Less than 12 months)	No healthcare coverage at all

**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 it applies to any member of the household

- Was your previous insurance policy cancelled in 2016?
- 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





### Other Income and Adjustments

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

#### Other Income

	2016 Taxpayer	2016 Spouse
Scholarships or grants not reported on form W-2 . . . . .	_____	_____
State income tax refund (attach Forms 1099-G) . . . . .	_____	_____
Alimony received . . . . .	_____	_____
Unemployment compensation (attach Forms 1099-G) . . . . .	_____	_____
Unemployment compensation repaid in 2016 . . . . .	_____	_____
Social Security Benefits (attach Forms 1099-SSA) . . . . .	_____	_____
Railroad Retirement Benefits (attach Forms 1099-RRB) . . . . .	_____	_____
Gambling winnings (attach Forms W2-G) . . . . .	_____	_____
Alaska Permanent Fund . . . . .	_____	_____
Other income: _____	_____	_____
_____	_____	_____
_____	_____	_____

#### Adjustments

	2016 Taxpayer	2016 Spouse
Educator expenses (If you are an educator, enter the amount you paid for classroom supplies) . . . . .	_____	_____
Contributions made to a Health Savings Account (HSA) . . . . .	_____	_____
Contributions made to a Self-Employed Pension plan (SEP) . . . . .	_____	_____
Payments made for Self-Employed Health Insurance for you, your spouse, or dependents . . . . .	_____	_____
Alimony paid		
Name: _____ SSN: _____	_____	_____
Name: _____ SSN: _____	_____	_____
Contributions made to an Individual Retirement Account (IRA) . . . . .	_____	_____
Contributions made to a Roth IRA . . . . .	_____	_____
Contributions made to a myRA . . . . .	_____	_____
Interest paid on a student loan . . . . .	_____	_____
Other adjustments: _____	_____	_____

#### Job-related Moving Expenses

	2016
Number of miles from old home to old workplace . . . . .	_____
Number of miles from old home to new workplace . . . . .	_____
Expenses to move household goods & personal effects and lodging expenses while traveling to your new home (Do not include cost of meals)	_____
<input type="checkbox"/> This was a military move	

**Schedule A - Itemized Deductions**

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

**Medical and Dental Expenses**

Health insurance premiums (paid by you) . . . . . \_\_\_\_\_  
 Long-term care premiums (you) . . . . . \_\_\_\_\_  
 Long-term care premiums (your spouse) . . . . . \_\_\_\_\_  
 Long-term care premiums (dependents) . . . . . \_\_\_\_\_  
 Mileage driven for medical purposes . . . . . \_\_\_\_\_  
 Medical and dental expenses  
     Doctor, dental, etc . . . . . \_\_\_\_\_  
     Prescription medicines . . . . . \_\_\_\_\_  
     Insulin . . . . . \_\_\_\_\_  
     Glasses and contacts . . . . . \_\_\_\_\_  
     Hearing aids . . . . . \_\_\_\_\_  
     Braces . . . . . \_\_\_\_\_  
     Medical equipment & supplies . . . . . \_\_\_\_\_  
     Hospital services . . . . . \_\_\_\_\_  
     Laboratory services . . . . . \_\_\_\_\_  
     Nursing services . . . . . \_\_\_\_\_  
     Other . . . . . \_\_\_\_\_

**Taxes Paid**

State and local income taxes . . . . . \_\_\_\_\_  
 Sales tax . . . . . \_\_\_\_\_  
 Real estate taxes . . . . . \_\_\_\_\_  
 Personal property taxes . . . . . \_\_\_\_\_  
 Other taxes (list) \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Interest paid**

Mortgage interest paid (attach Form 1098) . . . . . \_\_\_\_\_  
 Mortgage interest paid to an individual . . . . . \_\_\_\_\_  
 Paid to:  
     Name \_\_\_\_\_  
     Address \_\_\_\_\_  
     City, State, ZIP \_\_\_\_\_  
     SSN or EIN \_\_\_\_\_  
 Qualified mortgage insurance premiums . . . . . \_\_\_\_\_  
 Investment interest . . . . . \_\_\_\_\_

**Charitable Contributions**

Donations to Charity	Cash	Noncash	Amount
Church . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Boy or Girl Scouts . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goodwill . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red Cross . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salvation Army . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
United Way . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Veterans . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
University . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____

Miles driven for charitable purposes \_\_\_\_\_

**Job Expenses & Certain Misc. Deductions**

Necessary job expenses you paid that were not reimbursed by your employer

Safety equipment, tools, & supplies . . . . . \_\_\_\_\_  
 Uniforms . . . . . \_\_\_\_\_  
 Protective clothing (shoes, hardhats, glasses, etc.) \_\_\_\_\_  
 Dues to professional organizations . . . . . \_\_\_\_\_  
 Books & subscriptions . . . . . \_\_\_\_\_  
 Other . . . . . \_\_\_\_\_  
 Tax preparation fees . . . . . \_\_\_\_\_  
 Other nonpersonal expenses related to taxable income  
     Safe deposit box fees . . . . . \_\_\_\_\_  
     Investment expenses not entered elsewhere . . . . . \_\_\_\_\_  
     Other . . . . . \_\_\_\_\_

**Other Misc. Deductions**

Amortizable bond premiums . . . . . \_\_\_\_\_  
 Federal estate tax . . . . . \_\_\_\_\_  
 Gambling losses . . . . . \_\_\_\_\_  
 Impairment-related work expenses . . . . . \_\_\_\_\_  
 Claim repayments . . . . . \_\_\_\_\_  
 Unrecovered pension investments . . . . . \_\_\_\_\_  
 Loss from other activities from Schedule K-1 . . . . . \_\_\_\_\_  
 Ordinary loss debt instrument . . . . . \_\_\_\_\_

**Other Information**

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

**Mortgage Interest**

Attach all copies of Form 1098

Lender's name	Mortgage Interest Received	Mortgage Insurance Premiums	Real Estate Taxes Paid
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Employee Business Expense Not Reimbursed by Your Employer**

	NOT reimbursed by your employer	Reimbursed by your employer not included on your W-2
Rural mail carrier expenses . . . . .	_____	_____
Parking fees, tolls, local transportation . . . . .	_____	_____
Meals & entertainment . . . . .	_____	_____
Overnight business travel expenses (Do not include meals & entertainment) . . . . .	_____	_____
Other business expenses . . . . .	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

- |  |  |
|--|--|
| <input type="checkbox"/> You used your personal vehicle for your job during 2016 | <input type="checkbox"/> You are a fee-based state or local government official            |
| <input type="checkbox"/> You are a reservist                                     | <input type="checkbox"/> You are a disabled employee with impairment-related work expenses |
| <input type="checkbox"/> You are a qualified performing artist                   | <input type="checkbox"/> You are a member of the clergy                                    |

**Casualties and Thefts**

Property description _____	Property description _____
Property location _____	Property location _____
Date property was damaged or stolen _____	Date property was damaged or stolen _____
Cost of property damaged or stolen _____	Cost of property damaged or stolen _____
Amount of damage _____	Amount of damage _____
Insurance reimbursement _____	Insurance reimbursement _____

**Other Information**

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

**Child and Other Dependent Care Expenses**

Name of care provider	Address	SSN or EIN	Amount Paid

**Education Expenses**

Attach all copies of Form 1098-T

Student Name \_\_\_\_\_ Student Name \_\_\_\_\_

Type of Expense	Amount	Type of Expense	Amount

Student Name \_\_\_\_\_ Student Name \_\_\_\_\_

Type of Expense	Amount	Type of Expense	Amount