AFFORDABLE HEALTH CARE ACT – TAX YEAR 2014
Health Care Questionnaire

TAXPAYER Social Security Number or ITIN:

TAXPAYER Name:

1. Did you have Health Insurance for ***yourself and all your dependents*** for all 12 months of 2014?
   ☐ YES ☐ NO (if you answered NO, skip to question #5)

2. Did you receive form 1095-A, form 1095-B, or form 1095-C from your Employer, your insurance company, or HHS (U.S. Dept. of Health and Human Services)? ☐ YES ☐ NO

3. Did you receive any Health Care Premium Credits to assist in monthly payment for Health Insurance?
   ☐ YES ☐ NO If YES, how much did you receive each month? $_____

4. If YES in box #1, above…
   a. Did you purchase your Health Insurance through Market Place / Healthcare.gov? ☐ YES ☐ NO
   b. Did you purchase your Health Insurance directly from an Insurance Agent? . . . . ☐ YES ☐ NO
   c. Was your insurance provided by your employer? . . . . . ☐ YES ☐ NO
   d. Were you covered by Medicare or Medicaid? . . . . . ☐ YES ☐ NO

5. If NO in box #1, above…
   Did you or any of your dependents have health insurance for any part of the year 2014?
   ☐ YES ☐ NO
   If YES, what months did you **NOT** have coverage?

Taxpayer: ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec
Spouse: ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec
Dependents: ☐ Jan ☐ Feb ☐ Mar ☐ April ☐ May ☐ June ☐ July ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

6. Do you meet any of the following criteria for exemption of the 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 w/o coverage.
   ☐ You were incarcerated (detained or in jail).
   ☐ You were 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 an American Indian Tribe.
   ☐ You qualify for Hardship Exemption **(see list on next page)**.

(continued on next page)

You qualify for Hardship Exemption (check all that apply)

- ☐ You were homeless.
- ☐ You were evicted in the last 6 months of 2014 OR you were facing eviction or foreclosure.
- ☐ You received a shut-off notice from a utility company (anytime during 2014).
- ☐ You experienced domestic violence (spouse, son, daughter, family, neighbor anyone during year 2014).
- ☐ You experienced a death of a close family member in 2014.
- ☐ 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 2014.
- ☐ You had medical expenses you couldn't pay in 2013 or 2014 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's 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 didn't expand eligibility for Medicaid under the Affordable Care Act.
- ☐ Other_____

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NOTES

TAXPAYER'S STATEMENT

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

_____ _____

Taxpayer Signature Date

_____ _____

Spouse Signature Date