Affordable Care Act
Health Care Questionnaire

INFORMATION

TAXPAYER	**SSN or ITIN** (as shown on SSA Card) _ _ _ - _ _ - _ _ _ _

FIRST NAME	LAST NAME

1. Did you have Health Insurance for *yourself and all your dependents* all 12 months of 2014? ☐ **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 Yes in box 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 check NO in box #1

Did *you or any of your dependents* have health insurance for any part of the year 2014? ☐ YES ☐ NO

If yes, what months **DIDN'T** you 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 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);

PLEASE COMPLETE PAGE 2 OF THIS FORM →

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_____

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 return. 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: _____ **DATE** _____

Spouse: _____ **DATE** _____