***Affordable Care Act / ObamaCare***

***HEALTH INSURANCE QUESTIONAIRE***

***Required by the IRS & ObamaCare Act***

|  |
| --- |
| **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 □ NODid you purchase your Health Insurance directly from an Insurance Agent? □ YES □ NOWas your insurance provided by your employer? □ YES □ NOWere you covered by Medicare or Medicaid? □ YES □ NO |
| 5. If you check NO in box #1Did *you or any of your dependents* have health insurance for any part of the year 2014? □ YES □ NOIf yes, what months **DIDN’T** you have coverage Taxpayer: □ Jan □ Feb □ Mar □ April □ May □ June □ July □ Aug □ Sept □ Oct □ Nov □ DecSpouse: □ Jan □ Feb □ Mar □ April □ May □ June □ July □ Aug □ Sept □ Oct □ Nov □ DecDependents: □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 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**□** Your are member of American Indian Tribe**□** You qualify for Hardship Exemption (see list on next page) ***PLEASE COMPLETE THE BACK SIDE 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**