

Client:

2016 CLIENT QUESTIONNAIRE

Completed By: _____ Date _____ Email _____

1. Do you have a **new** Address, Phone #, or School District #? Yes / No Date of Move _____
2. Are you claiming the same **dependents** as last year? Yes / No *If new ones do they live with you?* Yes / No
PROVIDE SOCIAL SECURITY CARDS and DATE OF BIRTH FOR ALL NEW DEPENDENTS
3. Do you, your spouse, and dependents ALL have **Health Insurance**? Yes / No
4. Are you a beneficiary or executor for any **trusts or estates** this year? Yes/No
5. Did you buy anything & **not pay sales tax** (NOT FARM) (i.e. Internet/catalogue purchases)? Yes / No
6. Have you had any **debt forgiven this year**? (loans, credit cards, home, etc.) Yes / No
7. Did you make any contributions to an **OHIO 529 plan**? (child's college fund) Yes / No
8. Any **education** tuition for college? Yes/No If so, Provide 1098 and payment info Student loan interest? Y /N
9. Did you change employers and receive **unemployment** between jobs? Yes / No
10. Do you have accounts that you are authorized to draw from in a **Foreign Country** (not mutual funds)? Yes/No
11. Any **new** business / rentals / farm? Yes / No
12. Do you have an **IRA**? Yes/No Non Payroll IRA Contributions? Yes / No ROTH / Traditional (circle one)
13. Did you **start** receiving Social Security in 2016? Yes / No
14. Any **Misc Income** from various sources, Gambling, (online or in person) UBER, AirBnb, Online sales, Etc...?
15. Do you have a **Health Savings Account** at a bank? Y / N (not a flexible spending account) – provide statements
16. Do you have any of the following expenses for itemized deductions? Provide 1098 and documents
Medical Paid (Need 7-10% income) **Refi/New loans**? What were new loan \$'s used for? _____
17. **Daycare** expenses for children under age of 13? Yes / No *If yes, provide name, address, ID#.*
18. **Home Improvements** in 2016: Yes/No Have you taken any energy credit 2005-2015? Yes/No
Doors _____ Windows _____ Furnace _____ A/C _____ Water Heater _____ Metal Roof _____ Insulation _____
19. Did you make **Estimated tax payments** for 2016? None IRS Ohio City School **Bring checks**
20. Direct deposit info: SAME or Routing # _____ Checking or Savings # _____ **Attach copy check**
21. Did you have any correspondence and/or changes to prior tax returns by IRS, Ohio, or city? Yes / No
If so, please enclose copies.

ACA REQUIREMENT FOR HEALTH INSURANCE

In 2010, the Affordable Care Act (ACA) became law. Included in this law is the fact that by January 1, 2014, every American must have qualified health insurance or face a "shared Responsibility Payment" more commonly known as the Health Care Penalty.

To protect us both from future IRS liability and potential audit issues, we are requiring that you complete this form to assure us that you are in compliance. **Please initial each line, or put N/A if it is not applicable, and sign the bottom.**

_____ 1. We have provided you with all applicable copies of **Forms 1095-A, B and/or C** that we have received.

_____ 2. We did not receive all forms 1095-A because we have alternate government provided qualified health care insurance from **Medicare, Medicaid, or Tri-Care** that covers all members of our household and dependents.

_____ 3. We have **employer provided** qualified health care insurance for the entire year for our entire household and applicable dependents.

_____ 4. We have **other qualified health insurance** we purchased directly from an agent or insurance company for the entire year which covers our entire household and applicable dependents.

In the event that you **do not have qualified health insurance** for the **entire year** for your **entire household and dependents**, please provide us with the following information regarding insurance coverage for all members of your household and dependents. In the absence of the completion of items 1-4 above or item 5 below, and the absence of your providing us with information regarding an exemption from the requirement to provide health insurance, we will calculate the penalty and include it on your return. We must have your signature on this information to make it valid.

Name	Period of Coverage	Insurer/Employer

 Taxpayer signature
 Print Name _____
 Date _____

 Spouse signature
 Print Name _____
 Date _____