



# 5157A

## VITA/TCE Affordable Care Act - Taxpayer Scenarios

Volunteer Income Tax Assistance (VITA) / Tax Counseling for the Elderly (TCE)

2017 RETURNS



Take your VITA/TCE training online at [www.irs.gov](http://www.irs.gov) (keyword: Link & Learn Taxes). Link to the Practice Lab to gain experience using tax software and take the certification test online, with immediate scoring and feedback.



## How to Get Technical Updates?

Updates to the volunteer training materials will be contained in Publication 4491X, VITA/TCE Training Supplement. The most recent version can be downloaded at: <https://www.irs.gov/pub/irs-pdf/p4491x.pdf>.

### Volunteer Standards of Conduct

#### VITA/TCE Programs

The mission of the VITA/TCE return preparation programs is to assist eligible taxpayers in satisfying their tax responsibilities by providing **free** tax return preparation. To establish the greatest degree of public trust, volunteers are required to maintain the highest standards of ethical conduct and provide quality service.

All VITA/TCE volunteers (whether paid or unpaid workers) must complete the *Volunteer Standards of Conduct (VSC)* certification and agree to adhere to the VSC by signing Form 13615, *Volunteer Standards of Conduct Agreement*, prior to working at a VITA/TCE site. In addition, return preparers, quality reviewers, and VITA/TCE tax law instructors must certify in tax law prior to signing this form. This form is not valid until the site coordinator, sponsoring partner, instructor, or IRS contact confirms the volunteer's identity and signs and dates the form.

As a volunteer in the VITA/TCE Programs, you must:

1. Follow the Quality Site Requirements (QSR).
2. Not accept payment, solicit donations, or accept refund payments for federal or state tax return preparation.
3. Not solicit business from taxpayers you assist or use the knowledge you gained (their information) about them for any direct or indirect personal benefit for you or any other specific individual.
4. Not knowingly prepare false returns.
5. Not engage in criminal, infamous, dishonest, notoriously disgraceful conduct, or any other conduct deemed to have a negative effect on the VITA/TCE Programs.
6. Treat all taxpayers in a professional, courteous, and respectful manner.

Failure to comply with these standards could result in, but is not limited to, the following:

- Your removal from all VITA/TCE Programs;
- Inclusion in the IRS Volunteer Registry to bar future VITA/TCE activity indefinitely;
- Deactivation of your sponsoring partner's site VITA/TCE EFIN (electronic filing ID number);
- Removal of all IRS products, supplies, loaned equipment, and taxpayer information from your site;
- Termination of your sponsoring organization's partnership with the IRS;
- Termination of grant funds from the IRS to your sponsoring partner; and
- Referral of your conduct for potential TIGTA and criminal investigations.

TaxSlayer® is a copyrighted software program owned by Rhodes Computer Services. All screen shots that appear throughout the official Volunteer Income Tax Assistance (VITA) and Tax Counseling for the Elderly (TCE) training materials are used with the permission of Rhodes Computer Services.

#### Confidentiality Statement:

All tax information you receive from taxpayers in your volunteer capacity is strictly confidential and should not, under any circumstances, be disclosed to unauthorized individuals.



## Affordable Care Act (ACA) Exercises



### Instructions

The purpose of the following examples is to give volunteers an opportunity to practice completing forms and worksheets associated with the Affordable Care Act (ACA) tax provisions. Adequate information is provided to prepare simple tax returns with various health insurance coverage scenarios that you may encounter. Following each scenario are screen shots from the tax preparation software that will allow you to check your work. Note: This publication is posted before software and most tax forms are finalized.

### Reminders

- All taxpayer names, addresses and Social Security numbers provided in the scenarios are fictitious.
- When entering Social Security numbers (SSNs), replace the Xs as directed, or with any four digits of your choice.
- Use employer identification number (EIN) 622-00-XXXX for all W-2s.
- Complete tax return and intake sheet information is not provided. For the purposes of these exercises, you can ignore incomplete or missing information, or enter sample information of your choice.
- Use your city, state, and ZIP code when completing any forms, unless the notes state otherwise.
- For the purposes of the premium tax credit calculations on Form 8962, use “Other 48 states and DC” so your calculations will match the provided answers.
- For all scenarios, assume that the identity and Social Security cards were checked for all individuals on the intake sheet.

### Example 1 – Taxpayer with Partial Year Minimum Essential Coverage (MEC) and Coverage Exemption

#### Interview Notes

- Greg Clayton is single with no dependents. No one can claim him as a dependent.
- His SSN is 621-00-XXXX
- Greg left his old job on March 15. He was covered under his previous employer through the end of March. He began a new job on June 15th, and immediately became eligible for, and enrolled in, his employer sponsored health care coverage. Both employers withheld Greg’s share of the insurance premium pretax from his paycheck each week.
- Greg was uninsured from April 1 through June 14 of the tax year.
- Greg’s first W-2 shows the following:
  - Box 1 = \$15,200
  - Box 2 = \$1,520
  - Box 12 = \$1,456 with code DD



- Greg's second W-2 shows:
  - Box 1 = \$22,800
  - Box 2 = \$2,280
  - Box 12 = \$2,184 with code DD

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, personal information, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Greg.
2. Compare your result to the screen shots on the following pages.

Greg's intake sheet, page 1:

Form <b>13614-C</b> (October 2017)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>				OMB Number 1545-1964	
<b>You will need:</b> <ul style="list-style-type: none"> <li>• Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>• Social security cards or ITIN letters for all persons on your tax return.</li> <li>• Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>						<ul style="list-style-type: none"> <li>• Please complete pages 1-3 of this form.</li> <li>• You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>• If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>	
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>							
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)							
1. Your first name <b>GREG</b>		M.I.	Last name <b>CLAYTON</b>		Telephone number <b>YOUR PHONE #</b>		Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Your spouse's first name		M.I.	Last name		Telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Mailing address <b>55 CONCORD COURT</b>				Apt #	City <b>YOUR CITY</b>	State <b>YS</b>	ZIP code <b>YOUR ZIP</b>
4. Your Date of Birth <b>7/22/1987</b>		5. Your job title <b>SALES REP</b>		6. Last year, were you:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7. Your spouse's Date of Birth		8. Your spouse's job title		9. Last year, was your spouse:		a. Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No	
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure							
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
<b>Part II – Marital Status and Household Information</b>							
1. As of December 31, 2017, were you: <input checked="" type="checkbox"/> Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input type="checkbox"/> Married							
a. If Yes. Did you get married in 2017? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Greg's intake sheet, page 3:

Check appropriate box for each question in each section				Page 3													
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>														
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?														
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C														
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?														
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?														
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?														
Visit <a href="http://www.irs.gov">http://www.irs.gov</a> or call 1-800-318-2596 for more information on health insurance options and assistance.																	

Greg's Form 1095-B from Employer A:

<b>Part IV Covered Individuals</b> (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 GREG CLAYTON	621-00-XXXX	7/22/1987	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Greg's Form 1095-B from Employer B:

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 GREG CLAYTON	621-00-XXXX	7/22/1987	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Results – Approaching the ACA

Confirm with Greg the months that he had MEC, and indicate this on Part VI of his intake sheet:

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)						
Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer			J F M A M J J A S O N D	J F M A M J J A S O N D		Short coverage gap
Spouse			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

## Results – TaxSlayer ACA Responses

Greg's completed TaxSlayer health insurance input screens are shown below.

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2016?

☒ Yes

☐ No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

☐ Yes

☒ No

### Months Insured

Was your entire household insured for all 12 months of 2016? \*

☐ Yes

☒ No

Please enter the number of months insured for each household member.

Name	Months Insured
Greg Clayton	10

Enter the months that Greg had health insurance coverage. Remember that MEC coverage for one day during the month counts for the entire month. He has MEC for January through March and June through December.

## Months Insured - Greg Clayton

Specify the 10 months that Greg Clayton had minimum essential coverage

<input checked="" type="checkbox"/> January	<input checked="" type="checkbox"/> February	<input checked="" type="checkbox"/> March
<input type="checkbox"/> April	<input type="checkbox"/> May	<input checked="" type="checkbox"/> June
<input checked="" type="checkbox"/> July	<input checked="" type="checkbox"/> August	<input checked="" type="checkbox"/> September
<input checked="" type="checkbox"/> October	<input checked="" type="checkbox"/> November	<input checked="" type="checkbox"/> December

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Only complete this screen if the taxpayer is claiming the coverage is unaffordable exemption.

## Do you qualify for Health Care Exemptions?

To determine if you can claim the "Coverage is Unaffordable" exemption, you must enter the following premium values from your Form 8965 Worksheet. Use the link below to determine the premium amounts. If you already know this return would not qualify to claim the "Coverage is Unaffordable" exemption, please select continue below to continue through the Health Insurance menu.

**Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)**

\$

**Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)**


\$

[Click here to obtain the LCBP and SLCSP premium amounts to enter above.](#)  
[Click here to determine if you can claim a health coverage exemption.](#)

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Greg qualifies for a short coverage gap exemption for April and May.

## Health Care Exemption Certificates

 You do not qualify to claim the coverage exemption for household or gross income below the filing threshold, but if you received exemption certificates or can claim another coverage exemption, answer Yes below and then continue.

**Did you receive an exemption certificate from a marketplace or qualify to claim a coverage exemption on your return? \***

☒ Yes  
☐ No

[Click here to determine if you can claim a health coverage exemption.](#)

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Check the box for each month that the exemption applies.

## Health Insurance/Exemption

Name of Individual \*

Greg Clayton

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

Yes

No

Exemption Type on the return

Short gap in coverage

Indicate full year or specify months for which you qualify to take the exemption.

Full Year

January

February

March

April

May

June

July

August

September

October

November

December

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Continue

## Health Coverage Exemptions

+ Add another exemption

Name of Individual	Type	
Greg Clayton	B	<div><div></div><div></div></div>
<div><div>+ Add another exemption</div></div>		

Continue

Results – Form 1040, page 2

Greg will not be required to pay any shared responsibility payment. Greg's Form 1040, page 2 will not have the "Full-year coverage" box marked and will also not show an amount on the individual responsibility line.

60a	Household employment taxes. Schedule H		0
b	First-time homebuyer credit repayment. Form 5405		0
61	Health care: individual responsibility	Full-year coverage:	0
62	Taxes from	<div><div>Form 8959</div><div>Form 8960</div><div></div></div>	

## Example 2 – Coverage Exemptions

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### Interview Notes

- Jerome and Judy Baxter are married and file a joint return.
- They have one child, Jana, who they claim as a dependent on their return.
- Jerome's Form W-2 shows the following:
  - Box 1 = \$26,000
  - Box 2 = \$2,000
- Jerome, Judy, and Jana do not have any other income.
- Their Social Security numbers are:
  - Jerome: 623-00-XXXX
  - Judy: 624-00-XXXX
  - Jana: 625-00-XXXX
- Jerome's small employer offered health insurance for the tax year, but Jerome and Judy thought the premium was too expensive. The insurance Jerome was offered met the ACA's definition of an affordable employer coverage offer.
- Jerome and Judy were uninsured for all of 2017.
- They live in a state that did not expand Medicaid coverage to low-income adults.
- Jana was enrolled in Medicaid all year. All children in their state who are under the age of 18 are eligible for Medicaid with household income under 138% of FPL.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSNs, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Jerome and his family.
2. Compare your result to the screen shots on the following pages.



Form <b>13614-C</b> (October 2017)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>				OMB Number 1545-1964							
<b>You will need:</b> <ul style="list-style-type: none"> <li>Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>Social security cards or ITIN letters for all persons on your tax return.</li> <li>Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>						<ul style="list-style-type: none"> <li>Please complete pages 1-3 of this form.</li> <li>You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>							
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>													
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>JEROME</b>		M.I.	Last name <b>BAXTER</b>		Telephone number <b>YOUR PHONE #</b>		Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
2. Your spouse's first name <b>JUDY</b>		M.I.	Last name <b>BAXTER</b>		Telephone number		Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
3. Mailing address <b>33 APACHE WAY</b>				Apt #	City <b>YOUR CITY</b>	State <b>YS</b>	ZIP code <b>YOUR ZIP</b>						
4. Your Date of Birth <b>07/09/1979</b>		5. Your job title <b>SALES</b>		6. Last year, were you:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
7. Your spouse's Date of Birth <b>12/01/1983</b>		8. Your spouse's job title <b>HOMEMAKER</b>		9. Last year, was your spouse:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2017, were you: <input type="checkbox"/> Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input checked="" type="checkbox"/> Married a. If Yes, Did you get married in 2017? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Divorced b. Did you live with your spouse during any part of the last six months of 2017? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Legally Separated Date of final decree _____ <input type="checkbox"/> Widowed Date of separate maintenance agreement _____ Year of spouse's death _____													
2. List the names below: • <b>everyone</b> who lived with you last year (other than your spouse) • <b>anyone</b> you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
<b>To be completed by a Certified Volunteer Preparer</b>													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a) <b>JANA BAXTER</b>	(b) <b>02/04/2015</b>	(c) <b>DAUGHTER</b>	(d) <b>12</b>	(e) <b>YES</b>	(f) <b>YES</b>	(g) <b>S</b>	(h) <b>NO</b>	(i) <b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

Page 3												
Check appropriate box for each question in each section												
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>									
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?									
Visit <a href="http://www.healthcare.gov/">http://www.healthcare.gov/</a> or call 1-800-318-2596 for more information on health insurance options and assistance.												

## Results – Approaching the ACA

Complete the volunteer section of the Baxters' intake sheet, Part II:

<input type="checkbox"/> widowed Year of spouse's death: _____													
2. List the names below: • <b>everyone</b> who lived with you last year (other than your spouse) • <b>anyone</b> you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
<b>To be completed by a Certified Volunteer Preparer</b>													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a) <b>JANA BAXTER</b>	(b) <b>02/04/2015</b>	(c) <b>DAUGHTER</b>	(d) <b>12</b>	(e) <b>YES</b>	(f) <b>YES</b>	(g) <b>S</b>	(h) <b>NO</b>	(i) <b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

## Results – Exemption; Medicaid Coverage Gap

Consider the income-based exemptions Jerome and Judy may be eligible to claim. At \$26,000, their income is above the filing threshold, so they cannot claim the exemption on Line 7 of Form 8965.

Because they live in a state that did not expand Medicaid coverage, the Code G exemption will apply if their income is less than 138% of the federal poverty line (FPL). Use the table in Publication 4012, ACA tab, to find the income amount for a family of three at 138% FPL (\$27,821). Jerome and Judy's income (\$26,000) is less than 138% FPL, so they are eligible to claim Code G. Eligibility for affordable employer-sponsored coverage or coverage in the marketplace does not disqualify them from this exemption.

Complete the volunteer section of the Baxter' intake sheet, Part VI:

as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

**To be Completed by a Certified Volunteer Preparer** (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Medicaid coverage gap
Spouse		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Medicaid coverage gap
Dependent	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Covered by Medicaid
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

**Part VII – Additional Information and Questions Related to the Preparation of Your Return**

1. Presidential Election Campaign Fund (If you check a box, your tax or refund will not change)

## Results – TaxSlayer ACA Responses

Indicate that Jana was covered by Medicaid for the entire year and Jerome and Judy did not have health insurance coverage for any month during the year:

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2016?

- ☒ Yes  
☐ No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

- ☐ Yes  
☒ No

## Months Insured

Was your entire household insured for all 12 months of 2016? \*

- ☐ Yes  
☒ No

Please enter the number of months insured for each household member.

Name	Months Insured
Jerome Baxter	0 ▾
Judy Baxter	0 ▾
Jana Baxter	12 ▾

Continue past this screen. Jana did not have a filing requirement.

## Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37

\$

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

\$

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

\$

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

\$

Do not enter anything on this screen for the Baxters.

## Do you qualify for Health Care Exemptions?

To determine if you can claim the "Coverage is Unaffordable" exemption, you must enter the following premium values from your Form 8965 Worksheet. Use the link below to determine the premium amounts. If you already know this return would not qualify to claim the "Coverage is Unaffordable" exemption, please select continue below to continue through the Health Insurance menu.

**Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)**

\$

**Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)**

\$

[Click here to obtain the LCBP and SLCSPP premium amounts to enter above.](#)

[Click here to determine if you can claim a health coverage exemption.](#)

You have determined that Jerome and Judy qualify for a coverage exemption. Complete the remaining questions to claim the exemption for Jerome and Judy on the tax return.

## Health Care Exemption Certificates



You do not qualify to claim the coverage exemption for household or gross income below the filing threshold, but if you received exemption certificates or can claim another coverage exemption, answer Yes below and then continue.

Did you receive an exemption certificate from a marketplace or qualify to claim a coverage exemption on your return? \*

☒ Yes

☐ No

[Click here to determine if you can claim a health coverage exemption.](#)

Indicate that Jerome can claim a coverage exemption because his income is below 138% of FPL and he was a resident of a state that did not expand Medicaid. Make the same entries for Judy.

## Health Insurance/Exemption

Name of Individual \*

Jerome Baxter ▼

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

☐ Yes

☒ No

Exemption Type on the return

Resident of a state that did not expand Medicaid ▼

Indicate full year or specify months for which you qualify to take the exemption.

☒ Full Year

## Health Coverage Exemptions

[+ Add another exemption](#)

Name of Individual	Type		
Jerome Baxter	G		
Judy Baxter	G		



## Results – Form 8965 Part III

Part III Coverage Exemptions Claimed on Your Return for Individuals. If you and/or a member of your tax household are claiming an exemption on your return, complete Part III.																
	(a) Name of Individual	(b) SSN	(c) Exemption Type	(d) Full Year	(e) Jan	(f) Feb	(g) Mar	(h) Apr	(i) May	(j) June	(k) July	(l) Aug	(m) Sept	(n) Oct	(o) Nov	(p) Dec
8	JEROME BAXTER	623-00-XXXX	G	X												
9	JUDY BAXTER	624-00-XXXX	G	X												

## Results – Form 1040 Page 2

On Form 1040, the “Full-year coverage” box is not checked:

60a	Household employment taxes from Schedule H	0.00
b	First-time homebuyer credit repayment. Attach Form 5405 if required	0.00
61	Health care: individual responsibility (see instructions) Full-year coverage <input type="checkbox"/>	0.00
62	Taxes from: a <input type="checkbox"/> Form 8959 b <input type="checkbox"/> Form 8960 c <input type="checkbox"/> Instructions; enter code(s)	0.00
63	Add lines 56 through 62. This is your <b>total tax</b>	\$0.00
64	Federal income tax withheld from Forms W-2 and 1099	20,000.00

In this case, each member of the tax household had either coverage or a coverage exemption for each month so there is no individual shared responsibility payment required.

## Example 3 – Coverage Exemptions

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### Interview Notes

- Susan and Lee Parks are married and file a joint return.
- They have two children, Elisabeth and Emilee, whom they claim as dependents on their return.
- Susan's Form W-2 shows the following:
  - Box 1 = \$30,000
  - Box 2 = \$2,000
- Lee's Form W-2 shows the following:
  - Box 1 = \$27,000
  - Box 2 is \$2,700.
- Neither Susan, Lee, nor their children have any other income.
- Their Social Security numbers are:
  - Lee: 613-00-XXXX
  - Susan: 614-00-XXXX
  - Elisabeth: 615-00-XXXX
  - Emilee: 616-00-XXXX
- Lee's employer did not offer health insurance coverage for the tax year.
- Susan purchased self-only coverage under a plan offered by her employer.
- Susan had the option to purchase family coverage under an insurance plan offered by her employer which would have covered Susan, Lee, Elisabeth, and Emilee, at a cost of \$13,140. Susan and Lee could not afford this plan. Lee, Elisabeth and Emilee did not have health insurance coverage all year.
- The Parks don't qualify for any non-income-based coverage exemptions.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, dependents, personal information, and income. Then complete the following steps:

1. Determine if this couple is eligible for the affordability exemption. No other exemptions apply.
2. Select the Health Insurance section and answer all the questions pertaining to Susan, Lee, Elisabeth, and Emilee.
3. Compare your result to the screen shots on the following pages.

Form <b>13614-C</b> (October 2017)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>				OMB Number 1545-1964							
<b>You will need:</b> <ul style="list-style-type: none"> <li>Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>Social security cards or ITIN letters for all persons on your tax return.</li> <li>Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>						<ul style="list-style-type: none"> <li>Please complete pages 1-3 of this form.</li> <li>You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>							
<b>Volunteers are trained to provide high quality service and uphold the highest ethical standards.</b> <b>To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a></b>													
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>LEE</b>		M.I. <b></b>		Last name <b>PARKS</b>		Telephone number <b>YOUR PHONE #</b>							
2. Your spouse's first name <b>SUSAN</b>		M.I. <b></b>		Last name <b>PARKS</b>		Telephone number <b></b>							
3. Mailing address <b>87 HASTINGS BLVD</b>				Apt # <b></b>		City <b>YOUR CITY</b>							
4. Your Date of Birth <b>06/01/1968</b>		5. Your job title <b>CONSTRUCTION</b>		6. Last year, were you:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
7. Your spouse's Date of Birth <b>04/05/1970</b>		8. Your spouse's job title <b>SALES</b>		9. Last year, was your spouse:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure				11. Have you or your spouse:									
				a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2017, were you: <input type="checkbox"/> Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input checked="" type="checkbox"/> Married a. If Yes, Did you get married in 2017? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Divorced b. Did you live with your spouse during any part of the last six months of 2017? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Legally Separated Date of final decree _____ <input type="checkbox"/> Widowed Date of separate maintenance agreement _____ Year of spouse's death _____													
2. List the names below of: • <b>everyone</b> who lived with you last year (other than your spouse) • <b>anyone</b> you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
<b>To be completed by a Certified Volunteer Preparer</b>													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
<b>ELISABETH PARKS</b>	<b>03/02/2012</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>YES</b>	<b>NO</b>					
<b>EMILEE PARKS</b>	<b>09/07/2007</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>YES</b>	<b>NO</b>					

Page 3												
<b>Check appropriate box for each question in each section</b>												
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>									
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage? <b>SUSAN</b>									
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input checked="" type="checkbox"/> Form 1095-C									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?									
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?									
<a href="http://www.irs.gov/efile">http://www.irs.gov/efile</a> or call 1-800-348-2596 for more information on health insurance options and assistance.												

## Results – Exemptions; Insurance is Unaffordable

Complete the volunteer section on page 1 of the intake sheet:

<input type="checkbox"/> Widowed      Year of spouse's death      _____													
2. List the names below of: • <b>everyone</b> who lived with you last year (other than your spouse) • <b>anyone</b> you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
<b>To be completed by a Certified Volunteer Preparer</b>													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
<b>ELISABETH PARKS</b>	<b>03/02/2012</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>
<b>EMILEE PARKS</b>	<b>09/07/2007</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

Form 1095-B for Susan Parks:

Part IV Covered Individuals (Enter the information for each covered individual.)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 SUSAN PARKS	614-00-XXXX	04/05/1970	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form 1095-C for Susan Parks:

Form 1095-C		Employer-Provided Health Insurance Offer and Coverage		VOID		OMB No. 1545-2251									
Department of the Treasury Internal Revenue Service		Information about Form 1095-C and its separate instructions is at <a href="http://www.irs.gov/form1095c">www.irs.gov/form1095c</a>		CORRECTED		2017									
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>											
1 Name of employee SUSAN PARKS		2 Social security number (SSN) 614-00-XXXX		7 Name of employer EMPLOYER A		8 Employer identification number (EIN) 62-200XXXX									
3 Street address (including apartment no.) 87 HASTINGS BLVD		9 Street address (including room or suite no.) 1 FIRST AVENUE		10 Contact telephone number YOUR PHONE											
4 City or town YOUR CITY	5 State or province YS	6 Country and ZIP or foreign postal code YOUR ZIP	11 City or town YOUR CITY	12 State or province YS	13 Country and ZIP or foreign postal code YOUR ZIP										
<b>Part II Employee Offer and Coverage</b>				<b>Plan Start Month (Enter 2-digit number):</b>											
14 Offer of Coverage (enter required code) 1E		All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage \$ 260															
16 Applicable Section 4980H Safe Harbor (enter code, if applicable) 2C															
<b>Part III Covered Individuals</b>															
If Employer provided self-insured coverage, check the box and enter the information for each covered individual. <input type="checkbox"/>															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
17 SUSAN PARKS	614-00-XXXX	04/05/1970	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Susan had coverage all year so you do not need to determine if it was affordable. Next, determine if the coverage available to Lee, Elisabeth and Emilee is considered unaffordable.

The required contribution for Lee, Elisabeth, and Emilee is Susan's share of the cost for family coverage (\$13,140), which is more than 8.16% of their household income (\$57,000 x .0816 = \$4,651). As a result, Lee, Elisabeth, and Emilee are eligible for the exemption for unaffordable coverage for the tax year. Their Affordability Worksheet is completed below:



**(A) Affordability Threshold**

Enter 8.16% of your household income (see *Household Income*). For this purpose, increase household income by the amount of any premium that is paid through a salary reduction arrangement and excluded from gross income.

\$4651

**(B) Required Contribution Amount**

For each member of your tax household, enter in the columns provided the annual premium for the first option below that applies to that person. If the premium is the same for the whole year, enter the same value for each month. If the premium covers only part of the year, use the *Annualized Premium Worksheet* to determine what the annualized premium would be for each month.

Options (use the first that applies to each member of your tax household, including you, for each month):

1. The lowest cost self-only policy offered to each member of your tax household by his or her employer.
2. The lowest cost family policy\* offered by your employer or your spouse's employer (if you are filing a joint return).
3. The amount from the Marketplace Coverage Affordability Worksheet.

For each individual, coverage is unaffordable and the individual is exempt if (B), the Required Contribution Amount, is greater than (A), the Affordability Threshold.

Members of your tax household (enter one name per column):	Lee	Elisabeth	Emilee			
Premium for:						
January	13,140	13,140	13,140			
February	13,140	13,140	13,140			
March	13,140	13,140	13,140			
April	13,140	13,140	13,140			
May	13,140	13,140	13,140			
June	13,140	13,140	13,140			
July	13,140	13,140	13,140			
August	13,140	13,140	13,140			
September	13,140	13,140	13,140			
October	13,140	13,140	13,140			
November	13,140	13,140	13,140			
December	13,140	13,140	13,140			

\*The policy must cover everyone in your tax household:

- for whom a personal exemption deduction is claimed on your tax return,
- who is not eligible for employer coverage, and
- who does not qualify for another coverage exemption.

After you determine that the taxpayers are eligible for a coverage exemption, complete the volunteer section of the Part VI on the intake sheet:

If advance payments of the premium tax credit were paid on your behalf to help pay your health insurance premiums, you should report life changes, such as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer Lee		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Spouse Susan	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Employer coverage
Dependent Elisabeth		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Dependent Emilee		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

**Results – TaxSlayer ACA Responses**

Answer the ACA questions for Susan and Lee as shown below.

## Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2016?

☒ Yes

☐ No

# Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

☐ Yes

☒ No

Because Susan had minimum essential coverage all year, indicate that she was insured for 12 months.  
Because Lee, Elisabeth and Emilee had no insurance all year, indicate zero months for each.

## Months Insured

Was your entire household insured for all 12 months of 2016? \*

☐ Yes

☒ No

Please enter the number of months insured for each household member.

Name	Months Insured
Lee Parks	0 ▼
Susan Parks	12 ▼
Elisabeth Parks	0 ▼
Emilee Parks	0 ▼

The children do not have a filing requirement. Leave this screen blank.

## Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37

\$

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

\$

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

\$

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

\$

Follow the steps in Publication 4012, tab H, Coverage is Unaffordable page. Leave this screen blank for Susan and Lee.

## Do you qualify for Health Care Exemptions?

To determine if you can claim the "Coverage is Unaffordable" exemption, you must enter the following premium values from your Form 8965 Worksheet. Use the link below to determine the premium amounts. If you already know this return would not qualify to claim the "Coverage is Unaffordable" exemption, please select continue below to continue through the Health Insurance menu.

**Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)**

\$

**Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)**

\$

[Click here to obtain the LCBP and SLSP premium amounts to enter above.](#)

[Click here to determine if you can claim a health coverage exemption.](#)

Complete this section to claim coverage exemptions for Lee, Elisabeth and Emilee on the tax return.

## Health Care Exemption Certificates



You do not qualify to claim the coverage exemption for household or gross income below the filing threshold, but if you received exemption certificates or can claim another coverage exemption, answer Yes below and then continue.

**Did you receive an exemption certificate from a marketplace or qualify to claim a coverage exemption on your return? \***

☒ Yes

☐ No

[Click here to determine if you can claim a health coverage exemption.](#)

First enter the information for Lee.

## Health Insurance/Exemption

**Name of Individual \***

Lee Parks ▼

**Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \***

☐ Yes

☒ No

**Exemption Type on the return**

Coverage is unaffordable ▼



Indicate full year or specify months for which you qualify to take the exemption.

☒ Full Year

Then add additional exemptions for Elisabeth and Emilee.

## Health Coverage Exemptions







+ Add another exemption

Name of Individual	Type		
Lee Parks	A		
+ Add another exemption			

### Results – Health Coverage Exemptions

## Health Coverage Exemptions

+ Add another exemption

Name of Individual	Type		
Lee Parks	A		
Elisabeth Parks	A		
Emilee Parks	A		
+ Add another exemption			



## Results – Form 8965 Part III

Part III Coverage Exemptions Claimed on Your Return for Individuals. If you and/or a member of your tax household are claiming an exemption on your return, complete Part III.																
	(a) Name of Individual	(b) SSN	(c) Exemption Type	(d) Full Year	(e) Jan	(f) Feb	(g) Mar	(h) Apr	(i) May	(j) June	(k) July	(l) Aug	(m) Sept	(n) Oct	(o) Nov	(p) Dec
8	LEE PARKS	613-00-XXXX	A	X												
9	ELISABETH PARKS	615-00-XXXX	A	X												
10	EMILEE PARKS	616-00-XXXX	A	X												

## Results – Form 1040 Page 2

On Form 1040, the "Full-year coverage" box is not checked:

60a	Household employment taxes from Schedule H	60a	0 00
b	First-time homebuyer credit repayment. Attach Form 5405 if required	60b	0 00
61	Health care: individual responsibility (see instructions) Full-year coverage <input type="checkbox"/>	61	0 00
62	Taxes from: a <input type="checkbox"/> Form 8959 b <input type="checkbox"/> Form 8960 c <input type="checkbox"/> Instructions; enter code(s)	62	0 00

In this case, each member of the tax household had either coverage or a coverage exemption for every month so there is no individual shared responsibility payment required.

## Example 4 – Affordability Exemptions – Marketplace Coverage

---

### Interview Notes

- Edward and Julia Fulton are married and file a joint return. Their SSNs are:
  - Edward: 617-00-XXXX
  - Julia: 618-00-XXXX
- The Fultons have a dependent son, Sam. Sam worked part-time and earned enough that he was required to file a tax return this year. Sam's MAGI is \$6,900. Sam's SSN is 619-00-XXXX.
- Julia and Edward did not have minimum essential coverage for any month during the tax year. Edward and Julia mention that they looked into purchasing coverage through the Marketplace, but felt that the premiums were too expensive.
- Sam was covered all year by a government-sponsored Children's Health Plan.
- Edward's Form W-2 shows:
  - Box 1 = \$16,280
  - Box 2 = \$1,628
- Julia's W-2 shows:
  - Box 1 = \$17,000
  - Box 2 = \$0
- Edward and Julia had no other income.

### Directions

Explain that if their premium costs for Marketplace coverage is more than a certain percentage of their income, they would be eligible for an exemption from the SRP. Complete the worksheets in the Form 8965 Instructions to see if Edward and Julia qualify for the affordability exemption. Edward and Julia were not offered insurance coverage through their employers, so you'll need to complete two worksheets:

1. The Affordability Worksheet
2. The Marketplace Coverage Affordability Worksheet

<b>Form 13614-C</b> (October 2017)	Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>	OMB Number 1545-1964
<b>You will need:</b> <ul style="list-style-type: none"> <li>• Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>• Social security cards or ITIN letters for all persons on your tax return.</li> <li>• Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>		
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>		
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)		
1. Your first name <b>EDWARD</b>	M.I. <b>FULTON</b>	Telephone number <b>YOUR PHONE #</b>
2. Your spouse's first name <b>JULIA</b>	M.I. <b>FULTON</b>	Telephone number
3. Mailing address <b>456 STONEHILL RD</b>	Apt # <b>SAVANNAH</b>	State <b>GA</b> ZIP code <b>31405</b>
4. Your Date of Birth <b>06/01/1978</b>	5. Your job title <b>MANAGER</b>	6. Last year, were you: a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Your spouse's Date of Birth <b>01/06/1979</b>	8. Your spouse's job title <b>CUSTOMER SERVICE REP</b>	9. Last year, was your spouse: a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure		
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
<b>Part II – Marital Status and Household Information</b>		
1. As of December 31, 2017, were you: <input type="checkbox"/> Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input checked="" type="checkbox"/> Married a. If Yes, Did you get married in 2017? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Divorced b. Did you live with your spouse during any part of the last six months of 2017? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Legally Separated Date of final decree _____ <input type="checkbox"/> Widowed Date of separate maintenance agreement _____ Year of spouse's death _____		
2. List the names below of: • <b>everyone</b> who lived with you last year (other than your spouse) • <b>anyone</b> you supported but did not live with you last year		
If additional space is needed check here <input type="checkbox"/> and list on page 3		
<b>To be completed by a Certified Volunteer Preparer</b>		
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)
(a)	(b)	(c)
<b>SAM FULTON</b>	<b>05/19/2000</b>	<b>SON</b>
(d)	(e)	(f)
<b>12</b>	<b>YES</b>	<b>YES</b>
(g)	(h)	(i)
<b>S</b>	<b>YES</b>	<b>NO</b>
Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)
Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/NA)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)	

Page 3			
Check appropriate box for each question in each section			
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?

## Results – Affordability Worksheet

Complete the top of the Affordability Worksheet to determine the Affordability Threshold of the Household Income. Include the MAGI for a dependent, such as Sam, whose income exceeds the filing threshold.

The calculation is: \$40,180 x .0816 (affordability threshold for 2017) = \$3,279.

### Affordability Worksheet

Use this worksheet to determine whether coverage for each individual in your tax household is unaffordable. If you or another member of your tax household isn't eligible for employer-sponsored coverage, use the [Marketplace Coverage Affordability Worksheet](#) to figure the required contribution for that individual. An individual is exempt for any month in which (B), the Required Contribution, is more than (A), the Affordability Threshold.

#### (A) Affordability Threshold

Enter 8.16% of your household income (see [Household income](#)). For this purpose, increase household income by the amount of any premium that is paid through a salary reduction arrangement and excluded from gross income.

**\$3,279**

#### (B) Required Contribution Amount

Since Edward and Julia are not eligible for employer-sponsored coverage, they need to use the Marketplace Coverage Affordability Worksheet. Visit [www.healthcare.gov/tax-tool](http://www.healthcare.gov/tax-tool) to find the figures they will need to complete this worksheet:

- Remember to use their ages at the start of the tax year, since the first month they did not have coverage was January.
- Assume they live in zip code 31405 (Chatham County, GA) and do not use tobacco.
- Look up the lowest cost bronze plan for Edward, Julia and Sam. For this example, Sam is included in the calculation for the lowest cost bronze plan since he does not have an offer of employer coverage. Enter this amount on line 1 of the worksheet.
- Then look up the second lowest cost silver plan (SCLSP) for Edward and Julia. Do not include Sam in this quote because he has government-sponsored coverage. Enter this figure on line 10.

EDWARD FULTON

### Marketplace Coverage Affordability Worksheet

Use this worksheet to figure an individual's required contribution for any month in which the individual is not eligible for employer-sponsored coverage. Complete a separate worksheet for each part of the year in which either the individual resided in different geographic rating areas served by the Marketplace or for which the number of people in your tax household who are neither exempt nor eligible for employer-sponsored coverage was different.



*Do not complete this worksheet unless you were instructed to do so in the Affordability Worksheet.*

1. Enter the monthly premium for the lowest cost bronze plan that covers everyone in your tax household for whom a personal exemption deduction is claimed, who is not eligible for employer coverage, and who does not qualify for another coverage exemption for the month. To find the lowest cost bronze plan go to the Marketplace for your area .....	\$439
2. Enter your household income (see <u>Household income</u> ) .....	\$40,180
3. Enter the total of all nontaxable social security benefits received by you, your spouse, and each claimed dependent who must file a tax return* .....	
4. Add lines 2 and 3 .....	\$40,180
5. Enter the federal poverty line for the number of individuals in your tax household less any dependents not claimed. See the instructions for Form 8962, line 4 .....	\$20,160
6. Divide line 4 by line 5. If the result (without rounding) is less than 1.0 or more than 4.0, skip lines 7 through 10 and enter -0- on line 11. ....	1.993
7. Multiply line 6 by 100 and round to the nearest whole number. Enter the applicable figure for the result from the table in the instructions for Form 8962, line 7 .....	0.0638
8. Multiply line 4 by line 7 .....	\$2,563
9. Divide line 8 by 12.0 .....	\$214
10. Enter the monthly premium for the second lowest cost silver plan premium that covers everyone in your tax household for whom a personal exemption deduction is claimed, who is not eligible for minimum essential coverage (other than coverage in the individual market), and who does not qualify for another coverage exemption for the month. To find the second lowest cost silver plan go to the Marketplace for your area .....	\$495
11. Subtract line 9 from line 10 .....	\$281
12. Subtract line 11 from line 1. If zero or less, enter -0-. This is the individual's required contribution for the month .....	\$158
13. Is the individual eligible for this coverage for every month of the year?	
<input checked="" type="checkbox"/> <b>Yes.</b> Multiply line 12 by 12.0. This is the annualized premium. Enter this amount in the space for every month on the <u>Affordability Worksheet</u> .....	\$1,896
<input type="checkbox"/> <b>No.</b> Use the Annualized Premium Worksheet to determine what the annualized premium would be for each month the individual was eligible for the coverage being tested. Enter the annualized premium in the space for the appropriate months on the <u>Affordability Worksheet</u> .....	



Compare the annualized premium from line 13 of the Marketplace Coverage Affordability Worksheet to the Affordability Threshold. Because the annualized premium is lower than the 8.16% threshold, Edward and Julia can't claim the affordability exemption.

**(B) Required Contribution Amount**

For each member of your tax household, enter in the columns provided the annual premium for the first option below that applies to that person. If the premium is the same for the whole year, enter the same value for each month. If the premiums covers only part of the year, use the Annualized Premium Worksheet to determine what the annualized premium would be for each month.

Options (use the first that applies to each member of your tax household, including you, for each month):

1. The lowest cost self-only policy offered to each member of your tax household by his or her employer.
2. The lowest cost family policy\* offered by your employer or your spouse's employer (if you are filing a joint return).
3. The amount from the Marketplace Coverage Affordability Worksheet.

For each individual, coverage is unaffordable and the individual is exempt if (B), the Required Contribution Amount, is greater than (A), the Affordability Threshold.

Members of your tax household (enter one name per column):	Edward	Julia				
Premium for:						
January	\$1,896	\$1,896				
February	\$1,896	\$1,896				
March	\$1,896	\$1,896				
April	\$1,896	\$1,896				
May	\$1,896	\$1,896				
June	\$1,896	\$1,896				
July	\$1,896	\$1,896				
August	\$1,896	\$1,896				
September	\$1,896	\$1,896				
October	\$1,896	\$1,896				
November	\$1,896	\$1,896				
December	\$1,896	\$1,896				

\*The policy must cover everyone in your tax household:

- for whom a personal exemption deduction is claimed on your tax return,
- who is not eligible for employer coverage, and
- who does not qualify for another coverage exemption.

Complete Part VI of their intake sheet, indicating that Edward and Julia are not eligible for a coverage exemption.

If advance payments of the premium tax credit were paid on your behalf to help pay your health insurance premiums, you should report life changes, such as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

**To be Completed by a Certified Volunteer Preparer** (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer <b>Edward</b>		X	J F M A M J J A S O N D	J F M A M J J A S O N D		No exemption
Spouse <b>Julia</b>		X	J F M A M J J A S O N D	J F M A M J J A S O N D		No exemption
Dependent <b>Sam</b>	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Covered by CHP
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Because Edward and Julia did not have MEC were not eligible for an exemption, they must make an individual shared responsibility payment (SRP). Complete their return in the next example.

## Example 5 – Shared Responsibility Payment

For this scenario, use the same facts as Example 4.

Since Edward and Julia didn't have health insurance coverage for any month of the year and weren't eligible for an exemption, they must make a shared responsibility payment.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, dependents, personal information, and income. Then complete the following steps:

1. Complete the Health Insurance section of Edward and Julia's tax return.
2. Find the shared responsibility payment on the tax return and compare your results with the screen shots below.

### Results – TaxSlayer ACA Responses

Edward and Julia's completed Health Insurance section is shown below. Neither spouse had minimum essential coverage for any month, so you will indicate zero months insured for both taxpayer and spouse. Sam had full coverage all year, so you will indicate 12 months of coverage for him.

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2016?

☒ Yes

☐ No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

☐ Yes

☒ No

### Months Insured

Was your entire household insured for all 12 months of 2016? \*

- ☐ Yes
- ☒ No

Please enter the number of months insured for each household member.

Name	Months Insured
Edward Fulton	0
Julia Fulton	0
Sam Fulton	12

Because Sam's income exceeded the filing threshold, his MAGI is included in household income when calculating Edward and Julia's shared responsibility payment.

## Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37

\$ 6900

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

\$

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

\$

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

\$

Enter the amount of the lowest cost bronze level plan and second lowest cost silver level plan.

## Do you qualify for Health Care Exemptions?

To determine if you can claim the "Coverage is Unaffordable" exemption, you must enter the following premium values from your Form 8965 Worksheet. Use the link below to determine the premium amounts. If you already know this return would not qualify to claim the "Coverage is Unaffordable" exemption, please select continue below to continue through the Health Insurance menu.

**Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)**

\$ 443.54

**Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)**

\$ 499.48

[Click here to obtain the LCBP and SLSP premium amounts to enter above.](#)

[Click here to determine if you can claim a health coverage exemption.](#)

Edward and Julia were not eligible for the affordability exemption or any other exemption.

## Health Care Exemption Certificates



You do not qualify to claim the coverage exemption for household or gross income below the filing threshold, but if you received exemption certificates or can claim another coverage exemption, answer Yes below and then continue.

**Did you receive an exemption certificate from a marketplace or qualify to claim a coverage exemption on your return? \***

☐ Yes

☒ No

[Click here to determine if you can claim a health coverage exemption.](#)

## Results – Form 1040 Page 2

The shared responsibility payment will carry over to Edward and Julia's Form 1040, page 2, shown below:

<b>60a</b> Social Security and Medicare taxes from Schedule H	<b>60a</b>	0 00
<b>b</b> First-time homebuyer credit repayment. Attach Form 5405 if required	<b>60b</b>	0 00
<b>61</b> Health care: individual responsibility (see instructions) Full-year coverage <input type="checkbox"/>	<b>61</b>	1,390 00
<b>62</b> Taxes from: <b>a</b> <input type="checkbox"/> Form 8959 <b>b</b> <input type="checkbox"/> Form 8960 <b>c</b> <input type="checkbox"/> Instructions; enter code(s)	<b>62</b>	0 00





## Example 6 – Premium Tax Credit with Advance Credit Payments

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### Interview Notes

- Sheryl Graves has two children she claims as dependents, Trina and Travis, who live with her all year. She divorced in 2010. Sheryl pays all the costs of keeping up the home. Their SSNs are:
  - Sheryl: 605-00-XXXX
  - Trina: 606-00-XXXX
  - Travis: 607-00-XXXX
- Sheryl's mother, Monique Floyd, also lives with her. Sheryl provides over half of Monique's support and claims her as a dependent. Monique's SSN is 608-00-XXXX. Her only income for the tax year is \$4,500 received from Social Security and she was covered by Medicare all year.
- Sheryl's Form W-2 shows:
  - Box 1 = \$36,429
  - Box 2 = \$1,026
- Sheryl had no other income or deductions.
- Sheryl's employer does not offer health insurance coverage. She purchased minimum essential coverage for herself and her children through the Marketplace. They were covered for the entire year. Sheryl received the benefit of advance payments of the premium tax credit to help with the cost of her insurance premiums.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Sheryl and her family.
2. Compare your result to the screen shots on the following pages.

Form <b>13614-C</b> (October 2017)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>				OMB Number 1545-1964							
<b>You will need:</b> <ul style="list-style-type: none"> <li>Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>Social security cards or ITIN letters for all persons on your tax return.</li> <li>Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>						<ul style="list-style-type: none"> <li>Please complete pages 1-3 of this form.</li> <li>You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>							
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>													
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>SHERYL</b>		M.I.	Last name <b>GRAVES</b>		Telephone number <b>YOUR PHONE #</b>		Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
2. Your spouse's first name		M.I.	Last name		Telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. Mailing address <b>321 MARTIN ROAD</b>				Apt #	City <b>YOUR CITY</b>	State <b>YS</b>	ZIP code <b>YOUR ZIP</b>						
4. Your Date of Birth <b>06/17/1979</b>		5. Your job title <b>CLERK</b>		6. Last year, were you:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
7. Your spouse's Date of Birth		8. Your spouse's job title		9. Last year, was your spouse:		a. Full-time student <input type="checkbox"/> Yes <input type="checkbox"/> No							
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input type="checkbox"/> No							
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure				11. Have you or your spouse:									
				a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2017, were you: <input type="checkbox"/> Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)													
<input type="checkbox"/> Married a. If Yes, Did you get married in 2017? <input type="checkbox"/> Yes <input type="checkbox"/> No													
<input checked="" type="checkbox"/> Divorced b. Did you live with your spouse during any part of the last six months of 2017? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Date of final decree <b>4/27/2010</b>													
<input type="checkbox"/> Legally Separated Date of separate maintenance agreement _____													
<input type="checkbox"/> Widowed Year of spouse's death _____													
2. List the names below of: • everyone who lived with you last year (other than your spouse) • anyone you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
<b>To be completed by a Certified Volunteer Preparer</b>													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this taxpayer(s) have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
TRINA GRAVES	03/01/2001	DAUGHTER	12	YES	YES	S	YES	NO					
TRAVIS GRAVES	12/25/2002	SON	12	YES	YES	S	YES	NO					
MONIQUE FLOYD	05/05/1944	MOTHER	12	YES	YES	S	NO	NO					

Page 3									
Check appropriate box for each question in each section									
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?						
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?						
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?						

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 Monique Floyd	608-00-XXXX	05/05/1944	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form **1095-A****Health Insurance Marketplace Statement**☐ VOID

OMB No. 1545-2232

Department of the Treasury  
Internal Revenue Service

► Do not attach to your tax return. Keep for your records.  
► Go to [www.irs.gov/Form1095A](http://www.irs.gov/Form1095A) for instructions and the latest information.

☐ CORRECTED**2017****Part I Recipient Information**

1 Marketplace identifier <b>XXXXX</b>	2 Marketplace-assigned policy number <b>XXXXXX</b>	3 Policy issuer's name <b>XXXXXXXXXXXX</b>
4 Recipient's name <b>SHERYL GRAVES</b>	5 Recipient's SSN <b>605-00-XXXX</b>	6 Recipient's date of birth <b>05/17/1979</b>
7 Recipient's spouse's name	8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date <b>01/01/2017</b>	11 Policy termination date <b>12/31/2017</b>	12 Street address (including apartment no.) <b>321 MARTIN ROAD</b>
13 City or town <b>YOUR CITY</b>	14 State or province <b>YOUR STATE</b>	15 Country and ZIP or foreign postal code <b>YOUR ZIP</b>

**Part II Covered Individuals**

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16	SHERYL GRAVES	605-00-XXXX	05/17/1979	01/01/2017	12/31/2017
17	TRINA GRAVES	606-00-XXXX	03/01/2001	01/01/2017	12/31/2017
18	TRAVIS GRAVES	607-00-XXXX	12/25/2002	01/01/2017	12/31/2017
19					
20					

**Part III Coverage Information**

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January	\$587.00	\$774.00	\$492.00
22 February	\$587.00	\$774.00	\$492.00
23 March	\$587.00	\$774.00	\$492.00
24 April	\$587.00	\$774.00	\$492.00
25 May	\$587.00	\$774.00	\$492.00
26 June	\$587.00	\$774.00	\$492.00
27 July	\$587.00	\$774.00	\$492.00
28 August	\$587.00	\$774.00	\$492.00
29 September	\$587.00	\$774.00	\$492.00
30 October	\$587.00	\$774.00	\$492.00
31 November	\$587.00	\$774.00	\$492.00
32 December	\$587.00	\$774.00	\$492.00
33 Annual Totals	\$7,044.00	\$9,288.00	\$5,904.00

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60703Q

Form **1095-A** (2017)

## Results – Approaching the ACA

Complete the volunteer section of Sheryl's intake sheet on page 1:

☐ Widowed      Year of spouse's death: \_\_\_\_\_

2. List the names below of:  
 • **everyone** who lived with you last year (*other than your spouse*)  
 • **anyone** you supported but did not live with you last year

If additional space is needed check here ☐ and list on page 3

									To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
TRINA GRAVES	03/01/2001	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
TRAVIS GRAVES	12/25/2002	SON	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
MONIQUE FLOYD	05/05/1944	MOTHER	12	YES	YES	S	NO	NO	NO	NO	YES	YES	YES

Catalog Number 52121E      www.irs.gov      Form **13614-C** (Rev. 10-2017)

Complete Part VI of Sheryl's intake sheet after confirming her insurance coverage:

If advance payments of the premium tax credit were paid on your behalf to help pay your health insurance premiums, you should report life changes, such as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer <b>SHERYL</b>	X		J F M A M J J A S O N D	J F M A M J J A S O N D		MARKETPLACE
Spouse			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent <b>TRINA</b>	X		J F M A M J J A S O N D	J F M A M J J A S O N D		MARKETPLACE
Dependent <b>TRAVIS</b>	X		J F M A M J J A S O N D	J F M A M J J A S O N D		MARKETPLACE
Dependent <b>MONIQUE</b>	X		J F M A M J J A S O N D	J F M A M J J A S O N D		MEDICARE
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Sheryl's completed Health Insurance section is shown below. Because Sheryl, Trina, and Travis all had minimum essential coverage all year purchased through the Marketplace, select yes to the following question:

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

☒ Yes

☐ No

Because Sheryl, Trina, Travis all had minimum essential coverage all year purchased through the Marketplace and Monique was covered by Medicare all year, indicate the entire household was insured for all 12 months:

### Months Insured

Was your entire household insured for all 12 months of 2016? \*

☒ Yes

☐ No



Enter the information from Sheryl's Form 1095-A:

## Advanced Premium Tax Credit (1095-A)

Did you receive a 1095-A statement or any Premium Tax Credits to assist you in paying for your health care for 2016? \*

- ☒ Yes  
☐ No

Are you required to repay all of the APTC received? In most cases, the answer is NO. ONLY answer YES if you were not considered lawfully present in the U.S. or you meet the Health Coverage Tax Credit criteria. Note: We will automatically calculate a full repayment of APTC when MAGI is greater than 400 percent of Federal Poverty Line.

- ☐ Yes  
☒ No

Is your household income below 100% of the Federal poverty line, and do you meet all of the requirements under either "Estimated household income at least 100% of the Federal poverty line" or "Alien lawfully present in the United States"?

- ☐ Yes  
☒ No

Do all Forms 1095-A include coverage for January through December, with no changes in monthly amounts?

- ☒ Yes  
☐ No

Please enter your annual Advance Premium Tax Credit information

Premium Amount (Form 1095-A, line 33A)

\$7044

Annual Premium Amount of SLCSP (Form 1095-A, line 33B)

\$9288

Annual Advance Payment of PTC (Form 1095-A, line 33C)

\$5904

You do not need to enter an amount for the dependents' modified AGI because none of Sheryl's dependents were required to file a return.

## Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37

\$ 0

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

\$ 0

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

\$ 0

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

\$ 0

## Results – Form 1040, page 2

The software will check the "Full-year coverage" box to indicate that everyone listed on the ACA worksheet had insurance all year.

<b>60 a</b> Household employment taxes. Schedule H		0
<b>b</b> First-time homebuyer credit repayment. Form 5405		0
<b>61</b> Health care: individual responsibility	Full-year coverage: <input checked="" type="checkbox"/>	0
<b>62</b> Taxes from	<input type="checkbox"/> Form 8959 <input type="checkbox"/> Form 8960 <input type="checkbox"/>	

There is no amount on the individual responsibility line because all members of the tax household had full year coverage.

## Results – Premium Tax Credit Form 8962

<b>Form 8962</b> Department of the Treasury Internal Revenue Service Name shown on your return <b>Sheryl Graves</b>	<b>Premium Tax Credit (PTC)</b> ▶ Attach to Form 1040, 1040A, or 1040NR. ▶ Go to <a href="http://www.irs.gov/Form8962">www.irs.gov/Form8962</a> for instructions and the latest information.	OMB No. 1545-0074 <b>2017</b> Attachment Sequence No. <b>73</b>				
Your social security number		<b>605-00-XXXX</b>				
You cannot take the PTC if your filing status is married filing separately unless you qualify for an exception (see instructions). If you qualify, check the box <input type="checkbox"/>						
<b>Part I Annual and Monthly Contribution Amount</b>						
1 Tax family size. Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d	<b>1</b>	<b>4</b>				
2a Modified AGI. Enter your modified AGI (see instructions)	<b>2a</b>	<b>36429</b>				
b Enter the total of your dependents' modified AGI (see instructions)	<b>2b</b>	<b>0</b>				
3 Household income. Add the amounts on lines 2a and 2b (see instructions)	<b>3</b>	<b>36429</b>				
4 Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3 (see instructions). Check the appropriate box for the federal poverty table used. a <input type="checkbox"/> Alaska b <input type="checkbox"/> Hawaii c <input checked="" type="checkbox"/> Other 48 states and DC	<b>4</b>	<b>24300</b>				
5 Household income as a percentage of federal poverty line (see instructions)	<b>5</b>	<b>150 %</b>				
6 Did you enter 401% on line 5? (See instructions if you entered less than 100%) <input checked="" type="checkbox"/> No. Continue to line 7. <input type="checkbox"/> Yes. You are not eligible to take the PTC. If advance payment of the PTC was made, see the instructions for how to report your excess advance PTC repayment amount.						
7 Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions	<b>7</b>	<b>.0408</b>				
8a Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount	<b>8a</b>	<b>1486</b>				
b Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount	<b>8b</b>	<b>124</b>				
<b>Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit</b>						
9 Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage (see instructions)? <input type="checkbox"/> Yes. Skip to Part IV, Allocation of Policy Amounts, or Part V, Alternative Calculation for Year of Marriage. <input checked="" type="checkbox"/> No. Continue to line 10.						
10 See the instructions to determine if you can use line 11 or must complete lines 12 through 23. <input checked="" type="checkbox"/> Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12–23 <input type="checkbox"/> No. Continue to lines 12–23. Compute your monthly PTC and continue to line 24.						
<b>Annual Calculation</b>	<b>(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)</b>	<b>(b) Annual applicable SLSP premium (Form(s) 1095-A, line 33B)</b>	<b>(c) Annual contribution amount (line 8a)</b>	<b>(d) Annual maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)</b>	<b>(e) Annual premium tax credit allowed (smaller of (a) or (d))</b>	<b>(f) Annual advance payment of PTC (Form(s) 1095-A, line 33C)</b>
<b>11 Annual Totals</b>	<b>7044</b>	<b>9288</b>	<b>1486</b>	<b>7802</b>	<b>7044</b>	<b>5904</b>
<b>Monthly Calculation</b>	<b>(a) Monthly enrollment premiums (Form(s) 1095-A, lines 21–32, column A)</b>	<b>(b) Monthly applicable SLSP premium (Form(s) 1095-A, lines 21–32, column B)</b>	<b>(c) Monthly contribution amount (amount from line 8b or alternative marriage amount)</b>	<b>(d) Monthly maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)</b>	<b>(e) Monthly premium tax credit allowed (smaller of (a) or (d))</b>	<b>(f) Monthly advance payment of PTC (Form(s) 1095-A, lines 21–32, column C)</b>
<b>22 November</b>						
<b>23 December</b>						
24 Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here	<b>24</b>	<b>7044</b>				
25 Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here	<b>25</b>	<b>5904</b>				
26 Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Form 1040, line 69; Form 1040A, line 45; or Form 1040NR, line 65. If line 24 equals line 25, enter -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27	<b>26</b>	<b>1140</b>				
<b>Part III Repayment of Excess Advance Payment of the Premium Tax Credit</b>						



Column C of the 1095-A is entered in Column F of Form 8962.

## Results – Form 1040, page 2

68 American opportunity credit. Form 8863	0	
69 Net premium tax credit. Form 8962	1140	
70 Amount paid with request for extension of time to file	0	

## Example 7 – Premium Tax Credit with Advance Payments for Part-Year Coverage

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### Interview Notes

- Charles and Shay Baldwin are married with two dependent children, Nathaniel and Karly, who live with them all year. Their SSNs are:
  - Charles: 609-00-XXXX
  - Shay: 610-00-XXXX
  - Nathaniel: 611-00-XXXX
  - Karly: 612-00-XXXX
- Charles' Form W-2 shows:
  - Box 1 = \$33,500
  - Box 2 = \$1,820
- Shay's W-2 shows:
  - Box 1 = \$17,750
  - Box 2 = \$1,153
- Charles' and Shay's employers do not offer health insurance coverage. In early March, Charles enrolled in a plan through the Marketplace that covered him, Shay, and both children with an effective date of April 1. He selected the second lowest cost silver plan. They received the benefit of advance payments of the premium tax credit for their coverage. During the year, Charles received an unexpected raise in pay. They did not notify the Marketplace. The family has no other income or deductions.
- They received a marketplace exemption for January, February, and March.
  - Charles' ECN is A23BC56
  - Shay's ECN is A34BC67
  - Nathaniel's ECN is A45BC78
  - Karly's ECN is A56BC89

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSNs, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Charles, Shay, and their family.
2. Compare your result to the screen shots on the following pages.



Form <b>13614-C</b> (October 2017)	Department of the Treasury - Internal Revenue Service <h2 style="margin: 0;">Intake/Interview &amp; Quality Review Sheet</h2>	OMB Number 1545-1964
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**You will need:**

- Tax Information such as Forms W-2, 1099, 1098, 1095.
- Social security cards or ITIN letters for all persons on your tax return.
- Picture ID (such as valid driver's license) for you and your spouse.

**• Please complete pages 1-3 of this form.**  
**• You are responsible for the information on your return. Please provide complete and accurate information.**  
**• If you have questions, please ask the IRS-certified volunteer preparer.**

**Volunteers are trained to provide high quality service and uphold the highest ethical standards.**  
**To report unethical behavior to the IRS, email us at [wi.voltax@irs.gov](mailto:wi.voltax@irs.gov)**

**Part I – Your Personal Information** *(If you are filing a joint return, enter your names in the same order as last year's return)*

1. Your first name <b>CHARLES</b>	M.I.	Last name <b>BALDWIN</b>	Telephone number <b>YOUR PHONE #</b>	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Your spouse's first name <b>SHAY</b>	M.I.	Last name <b>BALDWIN</b>	Telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. Mailing address <b>775 BANKS ST</b>		Apt #	City <b>YOUR CITY</b>	State <b>YS</b> ZIP code <b>YOUR ZIP</b>
4. Your Date of Birth <b>12/03/1981</b>	5. Your job title <b>CUSTOMER SERVICE REP</b>	6. Last year, were you: b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
7. Your spouse's Date of Birth <b>06/10/1985</b>	8. Your spouse's job title <b>CASHIER</b>	9. Last year, was your spouse: b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

**Part II – Marital Status and Household Information**

1. As of December 31, 2017, were you: ☐ Unmarried (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)  
☒ Married a. If Yes, Did you get married in 2017? ☐ Yes ☒ No  
☐ Divorced b. Did you live with your spouse during any part of the last six months of 2017? ☒ Yes ☐ No  
☐ Legally Separated Date of final decree \_\_\_\_\_  
☐ Widowed Date of separate maintenance agreement \_\_\_\_\_  
Year of spouse's death \_\_\_\_\_

2. List the names below of:  
**• everyone** who lived with you last year *(other than your spouse)*  
**• anyone** you supported but did not live with you last year

If additional space is needed check here ☐ and list on page 3

Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yyyy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/16 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,050 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
NATHANIEL BALDWIN	04/04/2004	SON	12	YES	YES	S	YES	NO					
KARLY BALDWIN	04/29/2006	DAUGHTER	12	YES	YES	S	YES	NO					

**To be completed by a Certified Volunteer Preparer**

Check appropriate box for each question in each section			
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?

**Part I Recipient Information**

1 Marketplace identifier <b>XXXXX</b>	2 Marketplace-assigned policy number <b>XXXXX</b>	3 Policy issuer's name <b>XXXXXXXXXXXX</b>
4 Recipient's name <b>CHARLES BALDWIN</b>	5 Recipient's SSN <b>609-00-XXXX</b>	6 Recipient's date of birth <b>12/03/1981</b>
7 Recipient's spouse's name <b>SHAY BALDWIN</b>	8 Recipient's spouse's SSN <b>610-00-XXXX</b>	9 Recipient's spouse's date of birth <b>06/10/1985</b>
10 Policy start date <b>04/01/2017</b>	11 Policy termination date <b>12/31/2017</b>	12 Street address (including apartment no.) <b>775 BANKS ST</b>
13 City or town <b>YOUR CITY</b>	14 State or province <b>YOUR STATE</b>	15 Country and ZIP or foreign postal code <b>YOUR ZIP</b>

**Part II Covered Individuals**

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16	<b>CHARLES BALDWIN</b>	<b>609-00-XXXX</b>	<b>12/03/1981</b>	<b>04/01/2017</b>	<b>12/31/2017</b>
17	<b>SHAY BALDWIN</b>	<b>610-00-XXXX</b>	<b>06/10/1985</b>	<b>04/01/2017</b>	<b>12/31/2017</b>
18	<b>NATHANIEL BALDWIN</b>	<b>611-00-XXXX</b>	<b>04/04/2004</b>	<b>04/01/2017</b>	<b>12/31/2017</b>
19	<b>KARLY BALDWIN</b>	<b>612-00-XXXX</b>	<b>04/29/2006</b>	<b>04/01/2017</b>	<b>12/31/2017</b>
20					

**Part III Coverage Information**

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			
24 April	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
25 May	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
26 June	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
27 July	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
28 August	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
29 September	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
30 October	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
31 November	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
32 December	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
33 Annual Totals	<b>\$7,101.00</b>	<b>\$7,101.00</b>	<b>\$5,463.00</b>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60703Q

Form **1095-A** (2017)

## Results – Approaching the ACA

Complete the volunteer section of the Baldwins' intake sheet, Part II:

• everyone who lived with you last year (other than you or your spouse)  
• anyone you supported but did not live with you last year

If additional space is needed check here ☐ and attach page 3

										To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)	
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)						
NATHANIEL BALDWIN	04/04/2004	SON	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES	
KARLY BALDWIN	04/29/2006	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES	
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:vi.voltax@irs.gov">vi.voltax@irs.gov</a> or call toll free														
Catalog Number 52121E				www.irs.gov				Form <b>13614-C</b> (Rev. 10-2015)						

Complete the volunteer section of the Baldwins' intake sheet, Part VI:

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating minimum essential coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer <b>CHARLES</b>			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Spouse <b>SHAY</b>			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent <b>NATHANIEL</b>			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent <b>KARLY</b>			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Charles and Shay's completed Health Insurance section is shown below. Indicate that Charles, Shay, Nathaniel and Karly all had minimum essential coverage purchased through the Marketplace from April through December:

## Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

☒ Yes

☐ No

## Months Insured

Was your entire household insured for all 12 months of 2016? \*

- ☐ Yes  
☒ No

Please enter the number of months insured for each household member.

Name	Months Insured
Charles Baldwin	<input type="text" value="9"/>
Shay Baldwin	<input type="text" value="9"/>
Nathaniel Baldwin	<input type="text" value="9"/>
Karly Baldwin	<input type="text" value="9"/>

Indicate the months Charles had health insurance coverage. Do the same for Shay, Nathaniel, and Karly.

## Months Insured - Charles Baldwin

Specify the 9 months that Charles Baldwin had minimum essential coverage

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> January            | <input type="checkbox"/> February            | <input type="checkbox"/> March                |
| <input checked="" type="checkbox"/> April   | <input checked="" type="checkbox"/> May      | <input checked="" type="checkbox"/> June      |
| <input checked="" type="checkbox"/> July    | <input checked="" type="checkbox"/> August   | <input checked="" type="checkbox"/> September |
| <input checked="" type="checkbox"/> October | <input checked="" type="checkbox"/> November | <input checked="" type="checkbox"/> December  |

Enter the information from Form 1095-A:

## Advanced Premium Tax Credit (1095-A)

Did you receive a 1095-A statement or any Premium Tax Credits to assist you in paying for your health care for 2016? \*

- ☒ Yes  
☐ No

Are you required to repay all of the APTC received? In most cases, the answer is NO. ONLY answer YES if you were not considered lawfully present in the U.S. or you meet the Health Coverage Tax Credit criteria. Note: We will automatically calculate a full repayment of APTC when MAGI is greater than 400 percent of Federal Poverty Line.

- ☐ Yes  
☒ No

Is your household income below 100% of the Federal poverty line, and do you meet all of the requirements under either "Estimated household income at least 100% of the Federal poverty line" or "Alien lawfully present in the United States"?

- ☐ Yes  
☒ No

Do all Forms 1095-A include coverage for January through December, with no changes in monthly amounts?

- ☐ Yes  
☒ No

Please enter your monthly Advance Premium Tax Credit information

Month	Monthly Premium Amount (Form 1095-A, Part III, Column A)	Monthly Premium Amount of SLCP (Form 1095-A, Part III, Column B)	Monthly Advance Payment of PTC (Form 1095-A, Part III, Column C)
January	\$	\$	\$
February	\$	\$	\$
March	\$	\$	\$
April	\$789	\$789	\$607
May	\$789	\$789	\$607
June	\$789	\$789	\$607
July	\$789	\$789	\$607
August	\$789	\$789	\$607
September	\$789	\$789	\$607
October	\$789	\$789	\$607
November	\$789	\$789	\$607
December	\$789	\$789	\$607



The dependents did not have any income or filing requirement.

## Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37

\$ 0

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

\$ 0

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

\$ 0

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

\$ 0

Each family member received an exemption from the Marketplace for the months when they did not have health coverage:

## Health Care Exemption Certificates



You do not qualify to claim the coverage exemption for household or gross income below the filing threshold, but if you received exemption certificates or can claim another coverage exemption, answer Yes below and then continue.

Did you receive an exemption certificate from a marketplace or qualify to claim a coverage exemption on your return? \*

☒ Yes

☐ No

[Click here to determine if you can claim a health coverage exemption.](#)

Complete the exemption information for Charles, then add the information for Shay and both children:

## Health Insurance/Exemption

Name of Individual \*

Charles Baldwin ▼

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

☒ Yes

☐ No

Exemption Certificate Number (enter PENDING if applying or applied for)

A23BC56

Indicate full year or specify months for which you qualify to take the exemption.

☐ Full Year

☒ January

☒ February

☒ March

☐ April

☐ May

☐ June

☐ July

☐ August

☐ September

☐ October

☐ November

☐ December

## Health Coverage Exemptions

+ Add another exemption

Name of Individual	Type		
Charles Baldwin	Certificate A23BC56		

+ Add another exemption

## Health Coverage Exemptions

+ Add another exemption

Name of Individual	Type		
Charles Baldwin	Certificate A23BC56		
Nathaniel Baldwin	Certificate A45BC78		
Karly Baldwin	Certificate A56BC89		
Shay Baldwin	Certificate A34BC67		

+ Add another exemption

## Results – Exemptions, Form 8965

Each member of the family received a coverage exemption from the Marketplace for the months of January, February, and March. See Part I of the Baldwin's completed Form 8965:

<b>Form 8965</b> Department of the Treasury Internal Revenue Service		<b>Health Coverage Exemptions</b> ▶ Attach to Form 1040, Form 1040A, or Form 1040EZ. ▶ Go to <a href="http://www.irs.gov/Form8965">www.irs.gov/Form8965</a> for instructions and the latest information.		OMB No. 1545-0074 <b>2017</b> Attachment Sequence No. 75
Name as shown on return <b>Charles Baldwin</b>			Your social security number <b>609-00-XXXX</b>	
Complete this form if you have a Marketplace-granted coverage exemption or you are claiming a coverage exemption on your return.				
<b>Part I</b> <b>Marketplace-Granted Coverage Exemptions for Individuals.</b> If you and/or a member of your tax household have an exemption granted by the Marketplace, complete Part I.				
	(a) Name of Individual	(b) SSN	(c) Exemption Certificate Number	
1	CHARLES BALDWIN	609-00-XXXX	A23BC456	
2	SHAY BALDWIN	610-00-XXXX	A34BC567	
3	NATHANIEL BALDWIN	611-00-XXXX	A45BC678	
4	KARLY BALDWIN	612-00-XXXX	A56BC789	

## Results – Premium Tax Credit, Form 8962

See Parts 1, 2, and 3 of Charles and Shay's completed Form 8962 below. Part 3 of Form 8962 reconciles advance payments of the premium tax credit.

In this case, Charles failed to report an increase in pay to the Marketplace. This resulted in an excess advance premium tax credit repayment. This excess will decrease their refund or increase their balance due. Charles should have reported his change in income to the Marketplace so they could have adjusted his advance credit payments for the remainder of the coverage year.

**Premium Tax Credit (PTC)**

▶ Attach to Form 1040, 1040A, or 1040NR.

▶ Go to [www.irs.gov/Form8962](http://www.irs.gov/Form8962) for instructions and the latest information.

Charles Baldwin

Your social security number

609-00-XXXX

You cannot take the PTC if your filing status is married filing separately unless you qualify for an exception (see instructions). If you qualify, check the box ☐**Part I Annual and Monthly Contribution Amount**

1	Tax family size. Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d		1	4
2a	Modified AGI. Enter your modified AGI (see instructions)		2a	51250
b	Enter the total of your dependents' modified AGI (see instructions)		2b	0
3	Household income. Add the amounts on lines 2a and 2b (see instructions)		3	51250
4	Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3 (see instructions). Check the appropriate box for the federal poverty table used. a <input type="checkbox"/> Alaska b <input type="checkbox"/> Hawaii c <input checked="" type="checkbox"/> Other 48 states and DC		4	24300
5	Household income as a percentage of federal poverty line (see instructions)		5	210 %
6	Did you enter 401% on line 5? (See instructions if you entered less than 100%.) <input checked="" type="checkbox"/> No. Continue to line 7. <input type="checkbox"/> Yes. You are not eligible to take the PTC. If advance payment of the PTC was made, see the instructions for how to report your excess advance PTC repayment amount.			
7	Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions		7	.0679
8a	Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount		8a	3480
b	Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount		8b	290

**Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit**

- 9 Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage (see instructions)?  
☐ Yes. Skip to Part IV, Allocation of Policy Amounts, or Part V, Alternative Calculation for Year of Marriage. ☒ No. Continue to line 10.
- 10 See the instructions to determine if you can use line 11 or must complete lines 12 through 23.  
☐ Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12-23 and continue to line 24.  
☒ No. Continue to lines 12-23. Compute your monthly PTC and continue to line 24.

Annual Calculation	(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)	(b) Annual applicable SLSP premium (Form(s) 1095-A, line 33B)	(c) Annual contribution amount (line 8a)	(d) Annual maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Annual premium tax credit allowed (smaller of (a) or (d))	(f) Annual advance payment of PTC (Form(s) 1095-A, line 33C)	
11 Annual Totals							
Monthly Calculation	(a) Monthly enrollment premiums (Form(s) 1095-A, lines 21-32, column A)	(b) Monthly applicable SLSP premium (Form(s) 1095-A, lines 21-32, column B)	(c) Monthly contribution amount (amount from line 8b or alternative marriage monthly calculation)	(d) Monthly maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Monthly premium tax credit allowed (smaller of (a) or (d))	(f) Monthly advance payment of PTC (Form(s) 1095-A, lines 21-32, column C)	
12 January							
13 February							
14 March							
15 April	789	789	290	499	499	607	
16 May	789	789	290	499	499	607	
17 June	789	789	290	499	499	607	
18 July	789	789	290	499	499	607	
19 August	789	789	290	499	499	607	
20 September	789	789	290	499	499	607	
21 October	789	789	290	499	499	607	
22 November	789	789	290	499	499	607	
23 December	789	789	290	499	499	607	
24 Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here						24	4491
25 Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here						25	5463
26 Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Form 1040, line 69; Form 1040A, line 45; or Form 1040NR, line 65. If line 24 equals line 25, enter -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27						26	

**Part III Repayment of Excess Advance Payment of the Premium Tax Credit**

27	Excess advance payment of PTC. If line 25 is greater than line 24, subtract line 24 from line 25. Enter the difference here	27	972
28	Repayment limitation (see instructions)	28	1500
29	Excess advance premium tax credit repayment. Enter the smaller of line 27 or line 28 here and on Form 1040, line 46; Form 1040A, line 29; or Form 1040NR, line 44	29	972

For Paperwork Reduction Act Notice, see your tax return instructions.

Cat. No. 37784Z

Form **8962** (2017)

## Results – Form 1040, page 2

<b>45</b>	<b>Alternative minimum tax.</b> Attach Form 6251	0
<b>46</b>	<b>Excess advance premium tax credit repayment.</b> Form 8962	972

The “Full-year coverage” box is not checked.

<b>61</b>	<b>Health care: individual responsibility</b>	<b>Full-year coverage:</b> <input type="checkbox"/>	0
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# Link & Learn Taxes

**Link & Learn Taxes** is web-based training designed specifically for VITA/TCE volunteers. Each volunteer's ability to prepare complete and accurate returns is vital to the credibility and integrity of the program. Link & Learn Taxes, as part of the complete volunteer training kit, provides the path to achieving this high level of quality service.

Link & Learn Taxes and the printed technical training kit, Publication 4480, work together to help volunteers learn and practice.

## Link & Learn Taxes for 2017 includes:

- Access to all VITA/TCE courses
- Easy identification of the VITA/TCE courses with the course icons
  - As you progress through a lesson, the content for Basic, Advanced, Military, or International will display, depending on the level of certification you selected
- PowerPoint presentations that can be customized to fit your classroom needs
- VITA/TCE Central to provide centralized access for training materials and reference links
- The Practice Lab
  - Gives volunteers practice with an early version of the IRS-provided tax preparation software
  - Lets volunteers complete workbook problems from Publication 4491W
  - Lets volunteers prepare test scenario returns for the test/retest



Go to [www.irs.gov](http://www.irs.gov), type “Link & Learn” in the Keyword field and click Search. You’ll find a detailed overview and links to the courses.

**FSA (Facilitated Self Assistance)** empowers taxpayers to prepare their own returns with the assistance of a certified volunteer. Taxpayers complete their own returns using interview-based software supplied by leaders in the tax preparation industry. Volunteers assist taxpayers with tax law and software questions.

**Virtual VITA** allows partners to initiate the intake process for taxpayers in one location, while utilizing a certified volunteer to prepare the return in an entirely different location. By incorporating this flexibility, partners can provide taxpayers with more convenient locations to file their taxes.

**For more information contact your SPEC Relationship Manager to see if you should start a FSA or Virtual VITA site in your community.**



## Your online resource for volunteer and taxpayer assistance

### Partner and Volunteer Resource Center

<https://www.irs.gov/Individuals/Partner-and-Volunteer-Resource-Center>

- What's Hot!
- Site Coordinator's Corner

### Quality and Tax Alerts for IRS Volunteer Programs

<https://www.irs.gov/Individuals/Quality-and-Tax-Alerts-for-IRS-Volunteer-Programs>

- Volunteer Tax Alerts

### Volunteer Training Resources

<https://www.irs.gov/Individuals/Volunteer-Training-Resources>

### Outreach Corner

<https://www.irs.gov/Individuals/Outreach-Corner>

### Tax Trails for Answers to Common Tax Questions

<https://www.irs.gov/Individuals/Tax-Trails-Main-Menu>

### Online Services and Tax Information for Individuals

<https://www.irs.gov/Individuals>

#### File Your Return

- Direct Deposit your refund

#### Make a Payment

- Direct Pay
- Other ways you can pay  
(Electronic funds withdrawal,  
debit and credit card, and  
IRS2Go)

#### Manage Your Tax Info

- Withholding Calculator
- Answers about the Health Care Law
- Protect your identity

#### After You File

- Where's My Refund?
- Get Transcript

### eBooks

Want to view our training products on your mobile or tablet devices? Click here to access our eBooks: <https://www.irs.gov/Individuals/Site-Coordinator-Corner>.

### Mobile App

Another device to use for additional information is IRS2Go. Click here to download IRS2Go mobile app: <https://www.irs.gov/uac/irs2goapp>.

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