Tax Organizer

Taxpayer Information

First Name: Initial: Last Name:

Date of Birth: SSN#: Occupation:

Address: City:

State: Zip:

Home Tel: Work Tel:

Email

Filing Status

Single: Married: Married filing separately: Head of household: Qualified widow(er):

Spouse Information

First Name: Initial: Last Name:

Date of Birth: SSN#: Occupation:

Dependents

Name:	DOB:	SSN#:	Relationship:	Months at home:

Wage, Salary Income *(Provide W-2s)*

Employer Name:	Gross Wages:	Fed Withholdings:	State Withholdings:	Local Withholdings:

Other Income

Interest *(Provide 1099INT Forms)*

Payer:	Amount:	Payer:	Amount:
			$
			$
			$

Other Income *(Cont.)*

Dividends *(Provide 1099DIV Forms)*

Payer:	Total:	Capital Gains:	Ordinary Dividend:
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Capital Gains *(Provide 1099B and 1099S Forms)*

Description:	Date Acquired:	Date Sold:	Cost:	Sale Price:
			$	$
			$	$
			$	$
			$	$

Pension / IRA Distributions *(Provide 1099R Forms)*

Payer:	Gross Distribution:	Taxable Amount:	Roth Conversion:
	$	$	$
	$	$	$
	$	$	$
	$	$	$

Check if federal or state tax was withheld.

State tax refund *(Provide 1099G Forms)*

Amount Received: $

Alimony Received *(Not including child support)*

Payer: Payer SSN: Amount: $

Unemployment Received *(Provide 1099G Forms)*

Tax Payer Amount: $ Spouse Amount: $

Social Security Received *(Provide SSA-1099 Forms)*

Tax Payer Amount: $ Spouse Amount: $

Income from rental property *(Please fill out rental income section of this form)* $

Miscellaneous Income

Tips and gratuities (not on W-2) $ Bonuses and prizes $

Recovery of bad debts previously deducted $ Jury duty pay $

Gambling / Lottery winnings $ Disability Income $

Veteran's Pension $ Child Support $

Scholarships / Grants $

Other (Description and amount)

Deductions

Medical and dental expenses

Insurance Premiums: $ Doctors, Dentists, etc (net): $

Taxes Paid

State and local income tax: $ Real estate taxes (residence): $

Real estate taxes (other property, not rental): $ Auto registration & licensing: $

Other personal property tax: $ Foreign income tax (not taken as credit): $

Others $ Others $

Interest Paid *(Attach 1098 Forms)*

Home mortgage interest paid (1st): $ Home mortgage interest paid (2nd): $

Home mortgage (equity line): $ Student loan interest: $

Others $ Others $

Contributions *(Attach details)*

Cash or check: $ Other than cash: $

Miscellaneous Deductions

Unreimbursed employee business expenses: $ Tax return preparation fees: $

Investment council and advisory fees: $ Other professional fees: $

Safe deposit box rental: $ Educator expenses: $

Others $ Others $

Child and other dependent care expenses

Name of care provider: Address:

SSN or employee ID: Amount: $

Name of care provider: Address:

SSN or employee ID: Amount: $

Vehicle used for business

Business miles driven: Actual expenses: $

Education expenses

Interest paid on qualified student loans: $

Tuition fees

Student *(first, last name):*	SSN:	Expenses:
		$
		$
		$

Business Income

Cash basis: ☐ Accrual basis: ☐ First year: ☐ Tax payer: ☐ Spouse: ☐

Principal business / Profession ☐ Business name: ☐

Business Address: ☐

City: ☐ State: ☐ Zip: ☐

Other accounting method: ☐

Income

Gross receipts or sales $ ☐ Returns and allowances: $ ☐ Other income $ ☐

Cost of Goods Sold *(If Applicable)*

Inventory at beginning of year: $ ☐ Inventory at end of year: $ ☐

Purchases: $ ☐ Cost of items for personal use: $ ☐

Cost of labor: $ ☐ Materials and supplies: $ ☐

Other costs: $ ☐

Expenses

Advertising: $ ☐ *Car & truck expenses: $ ☐ Commissions: $ ☐

Employee benefit programs: $ ☐ Insurance other than health: $ ☐

*Health insurance premiums for self: $ ☐ Mortgage interest (paid to banks, etc): $ ☐

Other interest: $ ☐ Legal & professional: $ ☐ Office expense: $ ☐

Pension and profit sharing plans: $ ☐ Rent - vehicles machinery & equipment: $ ☐

Rent - other business property: $ ☐ Repairs: $ ☐ Supplies: $ ☐

Taxes - real estate: $ ☐ Taxes - other: $ ☐ Travel: $ ☐

*Other: $ ☐ Total meals & entertainment: $ ☐ Utilities: $ ☐

Wages: $ ☐

**Attach detailed schedule*

Check if you acquired or disposed of any business assets (including real estate) during the year. ☐
If yes, provide detailed schedule

Check if you had a home office during the year. ☐

Rent: $ ☐ Utilities: $ ☐ Insurance: $ ☐

Janitorial: $ ☐ Miscellaneous: $ ☐ % of exclusive business use: $ ☐

Rental Income

Check if any property was purchased/converted to rental last year: ☐

Property Address *(include city and state)*	Percentage ownership
1. ☐	% ☐
2. ☐	% ☐
3. ☐	% ☐

Rental Income *(Cont.)*

Property		1.	2.	3.
Income	Rents received:	$	$	$
Expenses	Advertising:	$	$	$
	Association dues:	$	$	$
	Auto and travel:	$	$	$
	Cleaning/Maintenance:	$	$	$
	Commissions:	$	$	$
	Gardening:	$	$	$
	Insurance:	$	$	$
	Labor:	$	$	$
	Professional fees:	$	$	$
	Miscellaneous:	$	$	$
	Mortgage interest:	$	$	$
	Other Interest:	$	$	$
	Repairs and Maintenance:	$	$	$
	Supplies:	$	$	$
	Taxes:	$	$	$
	Telephone:	$	$	$
	Utilities:	$	$	$
	Improvements:	$	$	$
	Other:	$	$	$

Adjustments to Income

	Tax Payer	Spouse
Traditional IRA Contributions:	$	$
Roth IRA Contributions:	$	$
Self Employed KEOGH, SEP & SIMPLE Contributions:	$	$

Alimony paid	SSN of Payee	Amount	SSN of Payee	Amount
	1.	$	2.	$

Estimated Tax Payments

Federal

Overpayment - Prior Year $

	Amount
1st Quarter Date	$
2nd Quarter Date	$
3rd Quarter Date	$
4th Quarter Date	$

State

Overpayment - Prior Year $

	Amount
1st Quarter Date	$
2nd Quarter Date	$
3rd Quarter Date	$
4th Quarter Date	$

HEALTH INSURANCE COVERAGE:

YOU MUST PROVIDE PROOF OF HEALTH INSURANCE COVERAGE BEGINNING ON JANUARY 1, 2014

The IRS requires that you report certain information related to your health care coverage on your 2014 tax return. Please read the following statements carefully. More than one might apply to your "tax family".

1. If you had compliant health insurance through an employer plan, private policy, or government plan, you will need to provide Form 1095-B, 1095-C or other proof of insurance document.

2. If you had health care coverage with a government Marketplace (Exchange) during 2014. Please provide Form 1095-A, issued by the Marketplace. In some family situations you may have more than one 1095-A.

3. If you are claiming dependent on your return who was included on another taxpayer's policy with a Marketplace, you will also need a copy of that taxpayer's 1095-A.

4. If your health care coverage is through a government Marketplace (Exchange) and a dependent on your return filed a tax return for 2014, you will need a copy of the return(s).

5. If you were issued a hardship exemption by the Marketplace (Exchange). Provide all applicable exemption certificate numbers issued for each member of your family.

6. Complete the information below if you or any individual included in your "tax family" did NOT have insurance coverage for any month of 2014. Please circle any months a member of your "tax family" was NOT insured.

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Name: _____

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

7. If you didn't have coverage for any part, or all of the year, please complete the following:

Answer YES if it applies to ANY member of the household. Please answer each question.

Yes No Was your previous insurance policy cancelled in 2014?

Yes No Are you a member of a federally-recognized Indian tribe?

Yes No Are you eligible for services through an Indian health care provider?

Yes No Are you a member of a health care sharing ministry?

Yes No Are you a member of a recognized religious sect with religious objects to insurance, including Social Security and Medicare?

Yes No Did you live in the United States the entire year?

Yes No Are you enrolled in TRICARE?

Yes No Did you apply for CHIP coverage?

Yes No Do any of the following "hardships" apply to you?

1. Became Homeless
2. Evicted in the past six months, or facing eviction or foreclosure
3. Received a shut-off notice form a utility company
4. Recently experienced domestic violence
5. You recently experienced the death of a close family member
6. Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
7. Filed for bankruptcy in the last six months
8. Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
9. Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member
10. You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child. In this case, you may not have to pay the penalty for the child.
11. As a result of an eligibility appeals decision, you're eligible for enrollment in a qualified health plan (QHP) through the Marketplace, lower costs on your monthly premiums, or cost-sharing reductions for a time period when you weren't enrolled in a QHP through the Marketplace
12. You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act
13. Your individual insurance plan was cancelled and you believe other Marketplace plans are unaffordable
14. You experienced another hardship in obtaining health insurance

_____ _____

Signature Date