2020 Tax Organizer
Personal and Dependent Information

Personal Information

	Name	SSN	Has IP PIN	Date of birth
Taxpayer		***-**-****		
Spouse				

Street address, city, state, and ZIP

	Occupation	Daytime phone	Evening phone	Cell phone
Taxpayer				
Spouse				

Taxpayer email	
Spouse email	

Marital Status at end of 2020

- ☐ Married
- ☐ Married filing separately
- ☐ Single
- ☐ Widow(er) If spouse died in 2020 enter the date of death _____

Other information

	Taxpayer		Spouse	
Are you blind?	☐ Yes	☐ No	☐ Yes	☐ No
Are you disabled?	☐ Yes	☐ No	☐ Yes	☐ No
Are you a full-time student?	☐ Yes	☐ No	☐ Yes	☐ No
Do you want $3 to go to the Presidential Election Campaign Fund?	☐ Yes	☐ No	☐ Yes	☐ No

At any time during 2020 did you receive, sell, send, exchange, or acquire any financial interest in any virtual currency? ☐ Yes ☐ No

Dependent Information

First and last name SSN	Has IP PIN	Relationship	Months in home	Date of birth	Disabled	Full-time student	Childcare Expenses

List dependents required to file a return _____

COVID-19 Implications

Yes	No	
☐	☐	Did you receive an Economic Impact Payment (EIP)? If "Yes," provide Notice 1444 from the IRS.
☐	☐	Did you experience economic loss due to COVID-19 (loss of job, closed business, etc.)?
☐	☐	Were you unemployed for any portion of the year due to COVID-19?
☐	☐	Did you continue to receive wages from your employer even if you were unable to work?
☐	☐	Did you receive a distribution from a retirement plan (401K, IRA, etc.) due to COVID-19?
		If you own a farm or business:
☐	☐	Did you continue to pay any employee while they were not working?
☐	☐	Did you delay withholding FICA taxes from any employee's pay?
☐	☐	Did you receive a Paycheck Protection Program (PPP) loan? If "Yes," was the loan forgiven or have you applied for forgiveness? _____
☐	☐	Were you unable to work due to COVID-19 and, if employed by someone other than yourself, would have qualified for sick or family leave?

Appointment Information

Your 2020 appointment is scheduled for _____

Additional Taxpayer Information

Name: SSN: ***-**-****

Estimates

	Federal		Resident state		Resident city	
	Date paid	Amount	Date paid	Amount	Date paid	Amount
Overpayment applied from 2019						
First quarter						
Second quarter						
Third quarter						
Fourth quarter						
Additional payments						

Account Information for Deposits or Withdrawals

Name of bank	Bank routing number	Bank account number	Type of account		Use this account for	
			Checking	Savings	Deposits	Withdrawals

Identfication Information

Taxpayer

Type of photo ID ☐ Driver's license ☐ State-issued photo ID

Driver's license or state-issued photo ID number _____

State the driver's license or state-issued photo ID was issued in _____

Issue date of the driver's license or state-issued photo ID _____

Expiration date of the driver's license or state-issued photo ID _____

Spouse

Type of photo ID ☐ Driver's license ☐ State-issued photo ID

Driver's license or state-issued photo ID number _____

State the driver's license or state-issued photo ID was issued in _____

Issue date of the driver's license or state-issued photo ID _____

Expiration date of the driver's license or state-issued photo ID _____

Healthcare Coverage Questionnaire

Name: SSN: ***-**-****

Healthcare Information

Member of household for healthcare purposes	Covered the entire year	Covered less than 12 months	No healthcare coverage at all

YES **NO**

☐ ☐ Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?

☐ ☐ Did you pay for healthcare coverage for anyone not listed above?

If you had coverage for any part of the year:

Where was the policy obtained?

Employer / Medicare / Medicaid / Marketplace(Exchange) / Other

If you didn't have coverage part or all of the year:

Answer YES if the following applies to any member of the household

☐ ☐ Was your previous insurance policy canceled in 2020?

☐ ☐ Was coverage offered by your employer or your spouse's employer?

☐ ☐ Are you a member of a federally recognized Indian tribe?

☐ ☐ Are you eligible for services through an Indian healthcare provider?

☐ ☐ Are you a member of a healthcare sharing ministry?

☐ ☐ Did you live in the United States the entire year?

☐ ☐ Are you enrolled in TRICARE?

☐ ☐ Did you apply for CHIP coverage?

☐ ☐ Do any of the following apply to you? Do NOT indicate which one.

- Became homeless
- Evicted in the past six months, or facing eviction or foreclosure
- Received a shut-off notice from a utility company
- Recently experienced domestic violence
- Recently experienced the death of a close family member
- Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
- Filed for bankruptcy in the last six months
- Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
- Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member