HealthCare Coverage Questionnaire

	Name	Covered Entire Year	NOT covered entire year	Covered Part Year (Specify Months not covered)
Taxpayer		☐	☐	
Spouse		☐	☐	
Dependent		☐	☐	
Dependent		☐	☐	
Dependent		☐	☐	
Dependent		☐	☐	

**Did you pay for healthcare coverage for anyone not listed above? ☐ YES ☐ NO

If you had coverage at any time during the year:

Where was the policy obtained? Circle ALL that apply

Employer/Medicare/TriCare/Medicaid/Marketplace (Exchange)*/Other: _____

*We MUST have your 1095-A in order to complete your return.

If you did NOT have coverage at any time during the year:

Answer YES if it applies to ANY member of the household

☐ YES ☐ NO Was coverage offered by your employer or your spouse's employer?
☐ YES ☐ NO Are you a member of a federally recognized Indian tribe?
☐ YES ☐ NO Are you eligible for services through an Indian healthcare provider?
☐ YES ☐ NO Are you member of a healthcare sharing ministry?
☐ YES ☐ NO Did you live in the United States for the entire year?
☐ YES ☐ NO Do you feel you would qualify for a hardship exemption?**

_____ _____

Taxpayer Signature Date

_____

Print Name

** If yes, we will contact you to discuss.