

Health Care Coverage Questionnaire

Name:

SSN:

Had health care coverage:	For the entire year	For part of the year (Less than 12 months)	No health care coverage at all

YES NO Did anyone besides taxpayer or spouse pay for health care coverage for anyone listed above?

YES NO Did you pay for health care 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 it applies to any member of the household

YES NO Was your previous insurance policy cancelled in 2014?

YES NO Do you have an Exemption from the Marketplace (also called the Exchange)?

YES NO Was coverage offered by taxpayer's or 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 health care provider?

YES NO Are you a member of a health care sharing ministry?

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 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

Health Care Coverage Questionnaire for taxpayer and spouse (for preparer use)

PRIMARY TAXPAYER

All Year
 January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Employer offered health coverage which was declined													
If YES, what would be the cost for SELF coverage?													
If YES, what would be the cost for FAMILY coverage?													
Would the FAMILY policy have covered the spouse?													

SPOUSE

All Year
 January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Employer offered health coverage which was declined													
If YES, what would be the cost for SELF coverage?													
If YES, what would be the cost for FAMILY coverage?													
Would the FAMILY policy have covered the spouse?													

Health Care Coverage Questionnaire for Dependents (for preparer use)

All Year January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A																				
Had health care coverage from another source																				
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.																				
Required to file a return?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	AGI of that return?																	

Insured through Marketplace (Exchange). MUST provide 1095-A																				
Had health care coverage from another source																				
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.																				
Required to file a return?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	AGI of that return?																	

Insured through Marketplace (Exchange). MUST provide 1095-A																				
Had health care coverage from another source																				
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.																				
Required to file a return?	YES <input type="checkbox"/>	NO <input type="checkbox"/>	AGI of that return?																	