# Tax Intake Form



***TAXPAYER***

Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

First Name: ____________________________ MI: __________ Last Name: ________________________

Date of Birth: ______________________________ Date of Death: _____________________________________

Work Phone: _______________________________ Cell/Other Phone: __________________________________

Occupation: ___________________________ Email: ___________________________________________

Legally Blind? Yes ________NO________ Dependent of Other? Yes ________NO________

***SPOUSE***

Social Security Number: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

First Name: ____________________________ MI: __________ Last Name: ________________________

Date of Birth: ______________________________ Date of Death: _____________________________________

Work Phone: _______________________________ Cell/Other Phone: __________________________________

Occupation: ___________________________ Email: ____________________________________________

Legally Blind? Yes ________NO________ Dependent of Other? Yes ________NO________

***FILING STATUS***

Single: __________

Married Filing Joint: __________

Married Filing Separately: _________

Head of Household: __________

Qualifying Widower: __________

***ADDRESS***

Street & Apt. No. _____________________________

City: _______________________________________

State: _____________ Zip: _________________

County: ____________________________________

***DEPENDENTS***

First, Middle initial, Last Name D.O.B Social Security Number Relationship

__________________________ _______________ ______________________ _______________

__________________________ _______________ ______________________ _______________

__________________________ _______________ ______________________ _______________

__________________________ _______________ ______________________ _______________

***AFFORDABLE CARE ACT***

Did **everyone** on this tax return have health insurance **all 12 months** last year? Yes _______ No _______

If **no**, were you exempt?Yes __________ No __________ If **yes**, Coverage through (circle one)

Taxpayer: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

Spouse: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

Dependent-1: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

Dependent-2: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

Dependent-3: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

Dependent-4: Employer Spouse Insurance Exchange/Marketplace Direct with Insurer Yes ___No___

**If not covered for all 12 months, Please provide Form 1095-A & complete Affordable Care Detail Intake Form.**

# Refund Type



## *How do you want your refund? (Check one of the following)*

- 7-14 days (RT Refund Transfer: Check)
  - In about 7-14 days from the date your return is accepted electronically by the IRS, you receive a check for the amount your refund less filing fees. (Check will be available in our office)
- 7-14 days (RT Refund Transfer: Debit Card)
  - In about 7-14 days from the date your refund is accepted electronically by the IRS, for the amount your refund less filing fees will be deposited onto the debit card we issued you.
- 7-14 days(RT Refund Transfer: Direct Deposit)
  - In about 7-14 days from the date your refund is accepted electronically by the IRS, for the amount your refund less filing fees will be deposited into your bank account.

## *The Following products require fees paid at the time of the service*

- E-file: Direct Deposit
  - Your refund will be deposited into your savings or checking account directly from IRS approximately 10-14 days after your return is accepted by IRS.
- 3-4 Weeks (E-file: Check)
  - Your refund will be mailed to you directly from IRS in approximately 3-4- weeks after your return is accepted electronically by the IRS.
- Mail a paper return
  - Your refund will be mailed to you directly from IRS in approximately 6-8- weeks after your mail your return to the IRS.

**Signature:** ____________________________________________________**Date:** ________________

*All times are estimated because the IRS no longer publishes the refund cycle chart

## For Office use only – Compliance check list

***Please make sure to collect, scan and upload all the listed item below to software***

- **2016 Client Intake Form** *(Please up load ALL the forms provided in the booklet)*
- **Tax Client Photo ID** *(Readable) (For every taxpayer listed on tax return)*
- **Copy of Social Security Cards**
- **Copy of Income** *(W-2, 1099 and all the other income documentation provided by taxpayer)*
- **Copy of any supporting documents pertaining to tax return** *(Any documents the taxpayer gives you scan and upload them)*

Tax Preparer Name: ____________________________________________ Date: _______________

# Tax Client Photo ID and Voided Check – Required!



Taxpayer Name - ____________________________________________

Taxpayer SSN - _____ _____ _____ - _____ ______ - _____ _____ _____ _____

**PHOTO ID #1 –Required**

**1 Other Form of ID – Required**

Spouse Name - ____________________________________________

Spouse SSN - _____ _____ _____ - _____ ______ - _____ _____ _____ _____

**PHOTO ID #1 –Required**

**1 Other Form of ID – Required**

**Place Voided Check Here**
**(only if you selected Direct deposit on page – 2)**

I hereby authorize the use of this identification above to electronically file my federal tax return according to IRS publication 1345

Taxpayer Signature: ______________________________ Date: ____________________

Spouse Signature: ______________________________ Date: ____________________

# Due Diligence Questionnaire



How many people live with you? _____ How many: Adults _____ Children _____

Did anyone else help support your during the year? _____ Yes _____ No

If yes, who? _______________________________________________ How much? $ __________

Are any of the Dependents being claimed NOT your Son or Daughter? _____ Yes _____ No

If Yes, Provide proof of financial responsibility or residency (i.e copy of lease, medical records, school records, food stamps or benefit statements)

If Yes, Why are parents not claiming the child? (Please explain and list the child's name(s) if more than one listed on the return)

Did you have any other income during the year? (Child support, alimony) _____ Yes _____ No

If yes, Please specify ____________________________________________________________

Other comments:

# Schedule – C – Form



Fill out COMPLETLEY or mark "N/A". DO NOT leave blank. Use a separate worksheet for EACH SCH - C

***Please Note: If possible, it is preferred a trial balance, P&L and balance sheet be provided by the client. If available, write "see next page" below and stuck under this page. If NOT AVAILABLE, Please use the input sheet below.*

**Business Info: (Required for all)** Taxpayer: _____ **or** Spouse: _____

Name of Business (If any): ______________________________

Address of Business: ______________________________

Business EIN (If any): _____ _____ - _____ _____ _____ _____ _____ _____ _____

Date Business Started: ____________________

Did you materially participate in the business? YES: _____

**2017 Income Questions: (Required if no P&L or Trial Balance Available)**

Total Sales: $____________________

Other Income: $____________________

**General Expenses: (Required if no P&L or Trial Balance Available)**

| | | | |
|---|---|---|---|
| Advertising: | $__________ | Repair & Maintenance: | $__________ |
| Auto Expense: | $__________ | Supplies: | $__________ |
| Commissions: | $__________ | Taxes & Licenses: | $__________ |
| Contract Labor | $__________ | Travel: | $__________ |
| Depletion | $__________ | Meals (Total): | $__________ |
| Employee Benefit Program: | $__________ | Utilities: | $__________ |
| Insurance (other than health): | $__________ | other: | |
| Interest: | $__________ | ______________ | $__________ |
| a) Mortgage: | $__________ | ______________ | $__________ |
| b) Other: | $__________ | ______________ | $__________ |
| Legal & Professional: | $__________ | ______________ | $__________ |
| Office Expense: | $__________ | ______________ | $__________ |
| Pension & Profit Sharing: | $__________ | ______________ | $__________ |
| Rent or Lease: | $__________ | ______________ | $__________ |
| a) Vehicles: | $__________ | ______________ | $__________ |
| b) Machinery: | $__________ | ______________ | $__________ |
| c) Other: | $__________ | ______________ | $__________ |

Total Expenses: $________________________

Total Income – Total Expenses = $____________ Net Income

(Please attach any other supporting document(s) if available)

Client Signature: ______________________________ Date: ____________

By signing above, I hereby certify the information given above is true and accurate.

# Income Summary



| ***MONTH*** | ***SERVICE*** | ***$ MADE*** |
|---|---|---|
| January | ________________________ | $________ |
| February | ________________________ | $________ |
| March | ________________________ | $________ |
| April | ________________________ | $________ |
| May | ________________________ | $________ |
| June | ________________________ | $________ |
| July | ________________________ | $________ |
| August | ________________________ | $________ |
| September | ________________________ | $________ |
| October | ________________________ | $________ |
| November | ________________________ | $________ |
| December | ________________________ | $________ |
| | TOTAL | $________ |

# Dependent Care Form



Taxpayer SSN: _____ _____ _____ - _____ _____ - _____ _____ _____ _____

Taxpayer Name: ____________________________________________

**STANDARD DEPENDANTS**

1. Name of child: ____________________________________________
   SSN: _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Daycare or provider Name: ____________________________________
   FEIN (or social of caregiver): _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Total amount paid $___________________

2. Name of child: ____________________________________________
   SSN: _____ _____ ______ - _____ _____ - _____ _____ _____ _____
   Daycare or provider Name____________________________________
   FEIN (or social of caregiver): _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Total amount paid $___________________

3. Name of child: ____________________________________________
   SSN: _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Daycare or provider Name________________________________
   FEIN (or social of caregiver): _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Total amount paid $___________________

4. Name of child: ____________________________________________
   SSN: _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Daycare or provider Name: ________________________________
   FEIN (or social of caregiver): _____ _____ _____ - _____ _____ - _____ _____ _____ _____
   Total amount paid $___________________

**NON STANDARD DEPENDENTS (Grandchild, niece, nephew, stepchild, foster child, etc.):**
Name of child ____________________________________________
Why aren't parents claiming child? ____________________________________________
How long has child lived with you? ___________ did parent send fund to help support child? **Y / N**
**Do you have**: Court documentation of custody? **Y / N**
Document proving relationship to child? **Y / N**

**ADULT DEPENDANTS**
Who is the dependent? ____________________________________________
Where do they live? ____________________________________________
Is dependent disabled? **Y / N**
Why are they not filing their own return? ____________________________________________
Can anyone else claim this dependent? **Y / N**

Client Signature ____________________________________________ Date: ___________________

By signing above, I hereby certify the information given above is true and accurate to the best of my knowledge.

# Student Acknowledgment Form



I, ______________________________________________________was a student during the 20_____ school year, and attended____________________________________________________________. I certify that all of the information found on this form is true and to the best of my knowledge. I understand it is my responsibility to have all valid documents and or receipts, as required to apply for any type of school credit. Below is a recap of all information, status, and expenses I have encountered.

**My scholar status:**

( ) Full Time Student

( ) Part Time Student

I ( ) **DID** receive a 1098-T Form

I ( ) **DID NOT** receive a 1098-T Form (Please visit 1098T.com to download your 1098T in order to claim the credit)

**Below are my total educational expenses**:

Books: $_________________

Supplies (On campus): $___________________

Supplies (Off campus): $ ___________________

Other expenses: $___________________

Total: $__________________

By signing below I certify all information is true, valid, and to the best of my knowledge. I accept full responsibility of the statements mentioned above. Any and all disputes regarding this matter shall be forwarded to me with the information found on my tax returns forms.

Name First/Last Name printed: ________________________________________________ Date: ________________

# Schedule - A – Information



| **MEDICAL EXPENSES** | **(Current Year)** |
|---|---|
| Medical & Dental Expenses | $______________ |
| Medical Insurance Premiums Paid (Other than Social Security Medicare Payments) | $______________ |
| Long Term care Premiums | $______________ |
| Prescription Drugs & Medications | $______________ |

Medical Miles Driven 1/1/17 to 6/30/17: ______________ 7/1/17 to 12/31/17: ________________

| **TAX EXPENSES** | **(Current Year)** |
|---|---|
| State & Local Income Taxes Paid (Other than those on W-2's, 1099's, etc.) | $______________ |
| 2016 Income Taxes paid in 2017 | $______________ |
| Real Estate Taxes | $______________ |
| Personal Property Taxes | $______________ |
| Other taxes: | |
| ____________________________ | $______________ |
| ____________________________ | $______________ |
| Qualified New Vehicle Taxes | $______________ |
| Additional State/ Local Taxes | $______________ |

| **INTEREST EXPENSE** | **(Current Year)** |
|---|---|
| Home Mortgage Interest reported on Form 1098 | $______________ |
| Home Mortgage Interest paid to others | $______________ |
| Refinancing Points Paid in 2017 | $______________ |
| Investment Interest (other than K-1) | $______________ |

| **CONTRIBUTIONS** | **(Current Year)** |
|---|---|
| Cash Contributions (If over $500 please provide detailed list) | $______________ |
| Non Cash Contributions (If over $500 please provide detailed list) | $______________ |
| Volunteer Mileage Driven ______________ | |

| **Miscellaneous** | **(Current Year)** |
|---|---|
| Unreimbursed Business Expenses | $______________ |
| Union Dues | $______________ |
| Tax Prep Fees (Paid for Previous Return) | $______________ |
| Safe Deposit Rental | $______________ |
| Investment Expenses (Other than K-1) | $______________ |
| Gambling Losses (Due to extent of winnings) | $______________ |
| Other Expenses: | |
| __________________________________ | $______________ |
| __________________________________ | $______________ |

**CASUALTY & THEFT LOSSES**

If you had any casualty or theft losses during the year, please provide detail below, including date, description, amount of casualty or loss, any insurance reimbursement & basis in the property.

______________________________________________________________________________

______________________________________________________________________________

Client Signature ________________________________________________________Date: __________________

# Affordable Care Details:



**Coverage Details: Check each month that applies for each question.**
**Note: 1095 - A and Exemption Certificates should be included under the Tax Document Sheet.**

| | | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **TAXPAYER:** | | | | | | | | | | | | | |
| Insured through Marketplace | | | | | | | | | | | | | |
| Coverage from other source | | | | | | | | | | | | | |
| Exempt from Mandate | | | | | | | | | | | | | |
| **SPOUSE:** | | | | | | | | | | | | | |
| Insured through Marketplace | | | | | | | | | | | | | |
| Coverage from other source | | | | | | | | | | | | | |
| Exempt from Mandate | | | | | | | | | | | | | |
| **DEPENDANT 1** | | | | | | | | | | | | | |
| Insured through Marketplace | | | | | | | | | | | | | |
| Coverage from other source | | | | | | | | | | | | | |
| Exempt from Mandate | | | | | | | | | | | | | |
| **REQUIRED TO FILE A RETURN?** | Y / N | | | | | | | | | | | | |
| **DEPENDANT 2** | | | | | | | | | | | | | |
| Insured through Marketplace | | | | | | | | | | | | | |
| Coverage from other source | | | | | | | | | | | | | |
| Exempt from Mandate | | | | | | | | | | | | | |
| **REQUIRED TO FILE A RETURN?** | Y / N | | | | | | | | | | | | |
| **DEPENDANT 3** | | | | | | | | | | | | | |
| Insured through Marketplace | | | | | | | | | | | | | |
| Coverage from other source | | | | | | | | | | | | | |
| Exempt from Mandate | | | | | | | | | | | | | |
| **REQUIRED TO FILE A RETURN?** | Y / N | | | | | | | | | | | | |

**If employer sponsored health coverage was declined:**

| | Taxpayer: | Spouse: |
|---|---|---|
| What would cost of SELF coverage have been? | $ | $ |
| What would cost of FAMILY coverage have been? | $ | $ |
| Would FAMILY policy have covered spouse? | Y / N | Y / N |

**Other Calculation Questions**

| | |
|---|---|
| Did you pay for health coverage for anyone not on your return? | Y / N |
| Did anyone else pay for health coverage for someone on your return? | Y / N |