Individual Income Tax Organizer Date: _____

Taxpayer Information	*Spouse Information*
First Name: _____ Middle Initial: _____	First Name: _____ Middle Initial: _____
Last Name: _____ Suffix: _____	Last Name: _____ Suffix: _____
SSN: _____ Date of Birth: _____	SSN: _____ Date of Birth: _____
Occupation: _____	Occupation: _____
Email: _____	Email: _____

Please circle primary contact: **Taxpayer** **Spouse** Please circle the best way to contact you: **Email** **Phone**

Taxpayer Phone #: _____ cell, work or home? Spouse Phone #: _____ cell, work or home?

Address: _____

City: _____ State: _____ Postal Code: _____

DEPENDENT INFORMATION

First Name	Last Name	Date of Birth	Social Security Number	Relationship
_____	_____	_____	_____	_____
		If dependent is older than 19, are they:	____ Full-time College Student	____ Disabled
_____	_____	_____	_____	_____
			____ Full-time College Student	____ Disabled
_____	_____	_____	_____	_____
			____ Full-time College Student	____ Disabled
_____	_____	_____	_____	_____
			____ Full-time College Student	____ Disabled

DIRECT DEPOSIT INFORMATION

Name of financial Institution: _____
Routing Transit Number: _____ Depositor Account Number: _____
Type of Account: _____ (Checking or Savings)

ESTIMATED TAXES PAID

	4/15/20	6/15/20	9/15/20	01/15/21
Federal Amount:	$_____	$ _____	$ _____	$_____
Date Paid:	_____	_____	_____	_____
State Amount:	$_____	$ _____	$ _____	$_____
Date Paid:	_____	_____	_____	_____

SPECIAL DEDUCTIONS

	Taxpayer	Spouse		Taxpayer	Spouse
IRA Contribution Amount:	_____	_____	Health Savings Account:	_____	_____
Distribution Amount:	_____	_____	HSA Distribution Amt:	_____	_____
	_____	_____	Student Loan Interest:	_____	_____
Rollover:	Yes ____ No ____	Yes __ No _____	Teaching Expense:	_____	_____
Type:	Traditional IRA: ___	Traditional IRA: __			
	Roth IRA: ___	Roth IRA: __			

Qualified Higher Education Tuition & Fees

Dependent: _____ Amount: $_____

Dependent: _____ Amount: $_____

ITEMIZED DEDUCTIONS

Medical Expense

Health insurance premiums
not including Medicare or pretax $ _____
Medical expenses not reimbursed
by insurance including vision,
dental, prescriptions, clinics,
& hospitals, etc. $_____

Long-term care insurance premiums $_____

Miles driven for medical purposes _____

Charitable Contributions

Cash or check donations: $ _____

Non-cash donations: $ _____
(if over $500, please include receipts)
Miles driven for volunteer work $ _____

Taxes Paid

Real Estate Taxes $ _____

Personal Property Taxes $ _____

Interest

Home Equity Interest $_____

Mortgage Interest $_____

Points paid on home purchase $_____
or refinancing and date

Miscellaneous Expense Deduction

Gambling Winnings $_____ Losses $_____

CREDITS

Child and Dependent Care

Provider name, address, social security or employer number & amount paid

1. _____ $ _____

2. _____ $ _____

3. _____ $ _____

Child name & amount paid (total for all children must equal total for all providers

1. _____ $ _____

2. _____ $ _____

3. _____ $ _____

Economic Impact Stimulus Payment

Did you receive? Yes or No

If yes, Amount Received: First Payment _____ Second Payment _____