

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

DIRECT DEPOSIT INFORMATION

Name of financial Institution: _____

Routing Transit Number: _____ Depositor Account Number: _____

Type of Account: _____ (Checking or Savings)

ESTIMATED TAXES PAID

	4/15/23	6/15/23	9/15/23	01/15/24
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 _____

Interest

Home Equity Interest \$ _____

Mortgage Interest \$ _____

Points paid on home purchase
or refinancing and date \$ _____

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 \$ _____

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. _____ \$ _____