Dependent Intake & Interview

Tax Yr.:____

List each person who lived in your home/ or whom you provided support for to determine your eligibility for Dependent Related Tax Credits.

Taxpayer Name: _____ Last 4 Social: _____ Spouse Name: _____ Last 4 Social: _____

	Dependent 1	Dependent 2	Dependent 3	Dependent 4
Dependent First Name				
Last Name				
Birth Date				
Social				
Relationship to you?				
How many months this person lived in your home?				
1. Is this person a U.S. Citizen or Resident? If no specify:	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
2. Can someone else claim this person as a dependent?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
3. Who provided more than 50% of this person's support?				
4. How much income did this person receive? Source?				
5. Did this person file a joint tax return?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
6. Could You produce proof of Relationship, Residency, and Support you provided for this person?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
7. Where are the parents if no parent is listed, -**or-** **where is the parent if only one parent is listed?**				
8. If you are not the parent, Did one of the parents live in home? If yes, what was the parents' income?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
9. Why are the parents not claiming this person -**or**- **Why is the other parent Not claiming this person (if one parent is listed)?**				

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	Dependent 1	Dependent 2	Dependent 3	Dependent 4
10. Has the **custodial parent**, released the claim of this child to the other parent? If so, Attach Form 8332	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
11. Did anyone else over the age 18 live in the home?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
12. Was this person a **full-time student** for at least half the year? If so, for how many months?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
12. Has a doctor, other health care, or social service provider, Stated this person is permanently and totally disabled?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
12a. If yes to 12 above, Did a doctor determine that the disability will last for one year or result in death?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
12b. Could you produce proof of the doctor's disability Certification, if necessary?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
13. Did this person have health insurance?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
13a. How many months during the year did this person have health insurance coverage?				
13b. How many months this person **did Not have health insurance?**				
13c. If this person did not have health insurance the entire year, what's the reason?				
14. Did you receive any of these health insurance forms for this person? If so, select which forms.	☐ 1095-A ☐ 1095-B / C ☐ FTB-3895	☐ 1095-A ☐ 1095-B / C ☐ FTB-3895	☐ 1095-A ☐ 1095-B / C ☐ FTB-3895	☐ 1095-A ☐ 1095-B / C ☐ FTB-3895
This space is for Tax Preparer Use Only Interviewer: _____ Date: _____ Preparer Reviewed: _____ Date: _____ Info Obtain By:	Notes: ☐ QC ☐ QR ☐ N	Notes: ☐ QC ☐ QR ☐ N	Notes: ☐ QC ☐ QR ☐ N	Notes: ☐ QC ☐ QR ☐ N

I declare under penalty of perjury that the information and answers on this form are true and correct to the best of my knowledge. I could provide proof.

Taxpayer Signature: _____ Date: _____ Spouse Signature: _____ Date: _____