3688 Pattons Creek Rd
Pendleton, KY 40055

www.rockcreektax.com
mg@rockcreektax.com
502-663-0067 – Office
502-376-0647 – Mobile

Client Tax Organizer
For the Year January 1 – December 31 20___.

Tax Payer Last Name	First Name	M.I	Social Security #

Spouse Last Name	First Name	M.I	Social Security #

Verification and Signature:

To the best of my knowledge the enclosed information is correct and included all income, deductions and other information necessary for the preparation of this year's income tax return for which I have adequate records.

Sign Here _____ Date _____

_____ Date _____

Appointment

Date and Time of appointment: _____

Please bring:

- Copies of two preceding years of tax returns (new clients only)
- All tax documents (W-2s, 1099s, 1099-Rx, K-1s, etc)

Bring original documents which we will copy and return to you, or legible copies that you can leave with us.

Identity Authentication (Driver's License or State Issued Identification)				
	State	Identification Number	Issue Date	Expiration Date
Taxpayer				
Spouse				

Client Tax Organizer

Please complete this Organizer before your appointment.

1. Personal Information

	Last Name	First Name, MI	Social Security #	Birth Date	Occupation
Taxpayer					
Spouse					

Street Address	City	State	Zip Code

Cell Phone	Work Phone	Home Phone	Email

Blind ___ Yes ___ No ___ Yes ___ No ___ Married Will file jointly ___ Yes
Disabled ___ Yes ___ No ___ Yes ___ No ___ Single ___ No
___ Widow(er) Date of Spouse's Death _____

2. Dependents (Children & Others)

Name (As Appears on Social Security card)	Relationship	Date of Birth	Social Security #	Months Lived with You	Disabled	Full Time Student

3. Estimated Taxes Paid

	Date Paid	Federal	State
First Quarter			
Second Quarter			
Third Quarter			
Fourth Quarter			

4. Refund Direct Deposit

Bank Name	
Bank Routing Number (9-Digit Number)	
Account Number	
Account Type	☐ Checking ☐ Savings

5. Interest Income (Please attach 1099-INTs & brokerage statements)

Payer	T/S/J	Bank or Credit Union	U.S. Bonds/T-Bills	Federal Tax Withheld	Municipal or Tax-Exempt

6. Dividend Income from Mutual Funds and Stocks (Please attach 1099-DIVs for each item listed below)

Payer	T/S/J	Total ordinary Dividends (Box 1a)	Qualified Dividends (Box 1b)	Capital Gain Distribution (Box 2a)	Federal Tax Withheld

7. Other Income (Please List all other Income)

Payer/Source	Taxpayer	Spouse	Federal Tax Withheld
Prizes, Bonuses, Awards			
Jury Duty			
Social Security Benefits			
Medicare Premiums Withheld			
Unemployment Compensation Received			
Gambling, Lottery			
Other Income			

8. Medical / Dental Expenses

To be deducted, medical expenses must exceed 7.5% of your adjusted gross income, and the only the amount that exceeds a 7.5% floor is deductible. Example: Your income is $40,000 for the year; your medical expenses must exceed $3000

	Amount			Amount
Acupuncture, Chiropractic			Lodging for Away-From-Home Medical Purposes	
Ambulance, Paramedics			Long-Term Care Insurance – Taxpayer	
Auto Travel for Medical Purposes		Miles	Long-Term Care Insurance – Spouse	
Braces			Medical Equipment, Supplies	
Doctors, Dentists			Medical Insurance Premiums (paid by you)	
Glasses, Contact Lenses			Nursing Home, Nursing Care	
Handicapped Modification to Home			Parking Fees for Medical Purposes	
Handicapped Placard			Prescription Drugs	
Hearing Aid, Batteries			Psychotherapy, Psychological Counseling	
Hospital			Other:	
Insulin				
Lab Fees & X-Rays			Insurance Reimbursement	( )

9. Home Mortgage Interest

If you have purchased, sold or refinanced your home this year, please bring your escrow papers with you.

Paid to Banks	Amount Paid
Mortgage Company:	
Mortgage Company:	
Mortgage Company:	
Home Equity Loan:	
Paid to Individuals	
Name:	Social Security #
Address	Amount Paid: $
Name	Social Security #
Address	Amount Paid: $

10. Taxes Paid

Real Estate Taxes	
Auto License Fees (vehicle license fee portion only)	
Property taxes on investment property	
Personal property tax – boat, etc	
Other Taxes:	

11. Charitable Contributions

	Cash Contributions
Church	
Payroll Deduction	
United Way	
Cancer Society	

Red Cross	
Scouts	
Other (please list)	
Volunteer (no. of miles)	
	Non-Cash Charitable Contributions

Description of Property Donated	Done Name	Fair Market Value

12. Child & Dependent Care Expenses

Care must enable you to work (or look for work) or attend school FULL TIME. Care must be for a child under age 13 or a dependent who is physically or mentally incapable of self care.

Care Provider Name	Address City, State, Zip	Phone #	Identifying # SSN or EIN	Amount Paid	Name of child cared for

***** If child care is for more than one child or dependent, please indicate how much was paid for **EACH** child or dependent.

13. Education Expenses – College or Other Continuing Education Expenses

Students Name	Type of Expense	Year of School	Amount

Student Loan Interest Paid

Taxpayer: $ _____ Spouse $: _____ Dependent(s) _____