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HEALTHCARE COVERAGE DUE DILIGENCE QUESTIONS

Taxpayer's Name	Social Security Number
Spouse's Name	**Social Security Number**

List every person listed on the tax return including yourself	Did this person have Health Coverage	Did they have Health coverage for the entire year	Did they have Health coverage for part of the year	Check here if they did not have Health coverage	Type of insurance? Marketplace/Obama? Employer? Medicaid? Medicare? Tricare? VA?

IF YOU or YOUR DEPENDENT DIDN'T HAVE COVERAGE PART OR ALL OF THE YEAR:

Yes ☐	No ☐	WAS YOUR INSURANCE POLICY CANCELED IN THE TAX YEAR?
Yes ☐	No ☐	DID YOU RECEIVE AN EXEMPTION FROM THE MARKETPLACE?
Yes ☐	No ☐	DID YOU RECEIVE FORM 1095A IN THE MAIL REGARDING HEALTHCARE?
Yes ☐	No ☐	DID YOU PAY FOR INSURANCE OUT OF POCKET OTHER THAN THROUGH THE MARKETPLACE?
Yes ☐	No ☐	ARE YOU ENROLLED IN TRICARE?
Yes ☐	No ☐	DID YOU APPLY FOR CHIP COVERAGE?
Yes ☐	No ☐	DID YOU EXPERIENCE A JOB LOSS, HOMLESS, FILED FOR BANKRUPTCY IN THE LAST 6 MONTH OR OTHER HARDSHIP?

By signing this form, you agree all the information provided is correct to the best of your knowledge. You understand that this information is being provided to file your Federal and State Return. Most information may be required to prove accuracy of the information provided. Keep records for 3 years.

Taxpayer's Signature ______________________________ Date ____________________

Spouse's Signature ______________________________ Date ____________________