

Tax Year _____

Client Tax Organizer

Tax Return Appointment: Date: _____ Time: _____

Please complete this Organizer before your appointment. Include all statements (W-2s, 1099s, etc.)

1. Personal Information		Taxpayer		Spouse	
First name & Initial					
Last name					
Social Security number					
Date of birth					
Occupation					
E-mail address					
Work phone	Cell		Work	Cell	
Home phone	Fax		Home	Fax	
Address				Apt/Suite	
City			State	ZIP	

Taxpayer Legally Blind Yes No Spouse Legally Blind Yes No
 Taxpayer Disabled Yes No Spouse Disabled Yes No
 Pres. Campaign Fund (Taxpayer) Yes No Pres. Campaign Fund (Spouse) Yes No
Filing status: Single Head of Household Married filing joint Married filing separate Widower Year of Spouse death? _____

2. Dependents (Children & Others)							
Name	Relationship	Date of Birth	Social Security Number	Months Lived With You	Disabled	Full Time Student	Dependent's Gross Income

Please answer the following questions to determine maximum deductions:

- | | |
|---|--|
| <p>1. Did your marital status change during the year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Did your address change during the year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Were there any changes in dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Did you receive unreported tip income of \$20 or more in any month? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Did you receive any unemployment or disability income? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Did you buy or sell any stocks, bonds or other investment property? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Did you purchase, sell, or refinance your principal home or second home, or take out a home equity loan? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Did you convert part or all of your traditional/SEP/SIMPLE IRA to a ROTH IRA? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Could you be claimed as a dependent on another person's tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Did you pay anyone for domestic services in your home? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Did you pay anyone for childcare services? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>12. Did you receive a distribution from or make a contribution to a retirement plan (401(k), IRA, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>13. Did you give a gift of more than \$14,000 to one or more people? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Did you go through bankruptcy, foreclosure, or repossession proceedings? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Did you incur a loss because of damaged or stolen property? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>16. Were you notified or audited by either the IRS or State taxing agency? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Did you work from a home office or use your car for business? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. May the IRS discuss your tax return with your preparer? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>19. Were you a citizen of, have income from, or live in a foreign country? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>20. Do you want to electronically file your tax return? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>21. Did you buy any internet merchandise for which you did not pay sales/use tax? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>22. Health Insurance. Did you have ACA compliant health insurance during the year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
|---|--|

(Attach Form 1095-A, 1095-B, and/or 1095-C)

13. Medical/Dental Expenses

Medical insurance premiums (paid by you) . . . _____
Long Term Care insurance _____
Prescription drugs _____
Glasses, contacts _____
Hearing aids, batteries _____
Braces _____
Medical equipment, supplies _____
Nursing care _____
Medical therapy _____
Hospital _____
Doctor/Dental/Orthodontist _____
Mileage _____

14. Taxes Paid

Real property tax (attach bills) _____
Personal property tax _____
Other: _____

15. Interest Expense

Mortgage interest paid (attach 1098's) _____
Interest paid to individual for your home
(attach amortization schedule) _____
Paid to:
Name _____
Address _____
Social Security No. _____
Investment interest _____

16. Casualty/Theft Loss

For property damaged by storm, water, fire, accident, or stolen.

Location of property _____

Description of property _____

Amount of damage _____
Insurance reimbursement _____
Repair costs _____
Federal grants received _____

17. Estimated Tax Payments

	Federal Amount		State Amount
LY - Jan 15	_____	LY - Jan 15	_____
Q1 - Apr 15	_____	Q1 - Apr 15	_____
Q2 - Jun 15	_____	Q2 - Jun 15	_____
Q3 - Sep 15	_____	Q3 - Sep 15	_____
Q4 - Jan 15	_____	Q4 - Jan 15	_____

18. Charitable Contributions (receipts required)

Church _____
United Way _____
Scouts _____
Telethons _____
University, Public TV/Radio _____
Heart, Lung, Cancer, etc. _____
Wildlife Fund., Humane society _____
Salvation Army, Goodwill _____
Other: _____
Non-Cash _____
Address _____
City/State/Zip _____
Value of goods (attach list if more than one) _____
Volunteer mileage _____

19. Miscellaneous/Unreimbursed Expenses

Dues - union, professional _____
Books, subscriptions, supplies _____
Licenses _____
Tools, equipment, safety equipment _____
Uniforms (including cleaning) _____
Sales expense, gifts _____
Tuition, Books (work related) _____
Entertainment _____
Tax preparation fee _____
Safe deposit box _____
IRA custodial fees _____
Investment periodicals, advisory fees _____
Job search expense _____
Moving of household goods (job related) _____
Other: _____
Other: _____

20. Day Care Expense (Form 2441)

Provider #1 _____
Address _____
City/State/ZIP _____
EIN/SS# _____ Amt Pd _____
Provider #2 _____
Address _____
City/State/ZIP _____
EIN/SS# _____ Amt Pd _____
Children cared for _____

Self Employment Information

Business Name

--

Total Sales		Taxpayer <input type="checkbox"/>	Spouse <input type="checkbox"/>
--------------------	--	-----------------------------------	---------------------------------

Expenses			
Advertising		Repairs Expense	
Commissions/Fees		Supplies Expense	
Dues & Publications		Taxes	
Interest Expense		Travel Expense	
Insurance		Meals & Entertainment	
Legal & Professional Fees		Telephone	
Office Expense		Utilities	
Rent (office) Expense		Wages (gross W-2)	
Equipment Rental Expense		Postage	
Auto Expense		Bank Charges	
Auto Mileage		Tools & Equipment	
		Uniforms	

Assets Purchased			Notes
Date	Amount	Asset	

Cost of Goods Sold	
Inventory at beginning of year	Material & supplies
Purchases	Other:
Cost of items for personal use	Other:
Cost of labor	Inventory at end of year

Rental Income	Property #1	Property #2	Property #3	Property #4
Address				
City/State				
Rent Received				
Expenses				
Advertising				
Auto & Travel				
Auto Miles				
Cleaning & Maintenance				
Commissions Paid				
Grounds & Gardening				
Insurance				
Interest Expense				
Legal & Professional				
Management Fees				
Repairs & Maintenance				
Supplies				
Taxes				
Utilities				
Association Dues				
Pest Control				
Other:				
Other:				
Other:				
Other:				
Other:				
Other:				

Health Care Coverage Questionnaire

YES <input type="checkbox"/>	NO <input type="checkbox"/>	Did anyone besides taxpayer or spouse pay for health care coverage for anyone listed above?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Did you pay for health care coverage for anyone not listed above?
<p>If you had coverage for any part of the year:</p> <p>Where was the policy obtained?</p> <p style="text-align: center;">Employer / Medicare / Medicaid / Marketplace(Exchange) / Other</p>		
<p>If you didn't have coverage part or all of the year:</p> <p>Answer YES if it applies to any member of the household</p>		
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Was your previous insurance policy cancelled in 2015?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do you have an Exemption from the Marketplace (also called the Exchange)?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Was coverage offered by taxpayer's or spouse's employer?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you a member of a federally-recognized Indian tribe?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you eligible for services through an Indian health care provider?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you a member of a health care sharing ministry?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Did you live in the United States the entire year?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Are you enrolled in TRICARE?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Did you apply for CHIP coverage?
YES <input type="checkbox"/>	NO <input type="checkbox"/>	Do any of the following apply to you? Do NOT indicate which one.
Became homeless		
Evicted in the past six months, or facing eviction or foreclosure		
Received a shut-off notice from a utility company		
Recently experienced domestic violence		
Recently experience and the death of a close family member		
Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property		
Filed for bankruptcy in the last six months		
Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt		
Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member.		

Health Care Coverage Questionnaire for Dependents

All Year January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A														
Had health care coverage from another source														
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.														
Required to file a return?	YES <input type="checkbox"/> NO <input type="checkbox"/>			AGI of that return?										

All Year January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A														
Had health care coverage from another source														
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.														
Required to file a return?	YES <input type="checkbox"/> NO <input type="checkbox"/>			AGI of that return?										

All Year January February March April May June July August September October November December

Insured through Marketplace (Exchange). MUST provide 1095-A														
Had health care coverage from another source														
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.														
Required to file a return?	YES <input type="checkbox"/> NO <input type="checkbox"/>			AGI of that return?										