

**ALPHA OMEGA TAX SERVICE 420 Odd Fellows Rd Crowley, LA 70526
Office 337-250-4240 Fax 866-295-5964**

**AFFORDABLE HEALTH CARE ACT
CLIENT INFORMATION FORM**

**COMPLETE THIS FORM AND BRING COMPLETED FORM
TO YOUR APPOINTMENT**

Or mail/fax in with other tax information

TAXPAYER NAME _____

SPOUSE NAME _____

Did you and **all** dependents have medical insurance for 2014? **YES**____ **NO**____

If **YES**, complete **PART ONE**. (Below) If **NO**, Complete **PART TWO** (turn page over)

PART ONE: MY INSURANCE WAS: (Circle option(s) number that apply)

1. THROUGH MY EMPLOYER: Employer Name _____

2. GOVERNMENT PLAN: (circle) Medicare—Medicaid—Other (Specify) _____

3. PRIVATE INSURANCE CARRIER: Carrier Name _____

Policy Number _____

4. MEDICAL MARKET EXCHANGE: (Federal or State) _____

BRING ALL FORMS 1095A, 1095B, or 1095c THAT YOU RECEIVED FROM YOUR PROVIDER(S).

Dates You were covered: _____, 2014 to _____, 2014

Dates Spouse was covered _____, 2014 to _____, 2014

Dates Dependents were covered _____, 2014 to _____, 2014

Were ALL Dependents claimed for 2014 covered for entire year? **YES**____ **NO**____

Explain any NO answer _____

IF YOU RECEIVED FORM 1095-A AND ARE CLAIMING THE CREDIT, INCOME INFORMATION FOR EACH DEPENDENT ON YOUR TAX RETURN WILL MOST LIKELY BE REQUIRED. IF ANY OF YOUR DEPENDENTS HAD INCOME, FIND OUT THE AMOUNT PRIOR TO YOUR TAX APPOINTMENT. THIS APPLIES ONLY IF YOU RECEIVED A FORM 1095-A.

Dependent #1 \$_____ Dependent #2 \$_____ Dependent #3 \$_____ Dependent #4 \$_____

IF MORE ROOM IS NEEDED FOR EXPLANATIONS, PLEASE SEE REVERSE SIDE.

AFTER COMPLETING PART ONE, PLEASE TURN PAGE AND SIGN WHERE INDICATED.

PART TWO: Complete ONLY if not covered for ANY part of 2014. SEE REVERSE SIDE

PART TWO: Complete ONLY if not covered for any part of 2014.

If your family did not have coverage all year, do any of the following reasons apply?

- Short term coverage gap of 3 months in a row – claim exemption on tax return.
- Religious objection – claim this at the MNsure marketplace and obtain a certificate
- Health care sharing ministry – claim this on tax return.
- Member of an Indian tribe or Alaska Native tribe – claim on tax return or MNsure marketplace
- Incarceration – claim on tax return or MNsure marketplace
- Hardship (Explain Below)

HARDSHIPS – many of these hardships need to be claimed with MNsure and you need to obtain a certificate

- Homeless Evicted in past 6 months Ineligible for Medicaid
- Received shut-off notice from a utility company Filed for bankruptcy in last 6 months
- Recently experienced domestic violence Death of close family member
- Current health insurance plan cancelled Dependent child denied coverage
- Unable to pay medical expenses in last 24 months Eligible appeals decision
- Experienced fire, flood, or other natural or human-caused disasters
- Unexpected** increase in necessary expense due to caring for ill, disabled, or aging family member
- Another hardship in obtaining health insurance (explain)_____

 Other reason (explain)

Please supply copy of proof for above hardship Exemptions

When you sign here you are stating that you have read and understand all of the tax topics on both sides of this page and that you have marked and completed all topics that pertain to you and your spouse.

I/we have asked my/our tax preparer about any tax topic about which I/we have any question.

TAXPAYER (AND SPOUSE IF A JOINT RETURN) MUST SIGN BELOW AND DATE:

TAXPAYER _____ DATE _____

SPOUSE _____ DATE _____