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Client Health Care Questionnaire Form

Taxpayer Name: _____

1. Did you and everyone in your family have health care coverage for every month of 2017? _____ yes _____ no

   Please complete the worksheet below: For Taxpayer and all dependents listed by name. Circle the months that you are covered by healthcare. No circles indicate no health coverage.

NAME	Insurance Provider	Source (Employer, Exchange, or Government)	Months of 2017 Covered (circle as appropriate)
			ALL J F M A M J J A S O N D
			ALL J F M A M J J A S O N D
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NOTE: Our office will need copies of the health insurance cards or other documentation showing proof of insurance to support the above health coverage.

Important Note: If you have signed up on the Market Place, you will be receiving Form 1095A Health Insurance Market Place Statement. *We will need this statement before we can file the return. If you file a return without this statement, and the information is different than reported this could cause an extended delay in your tax refund.

Please call the office if you have any questions. We will be glad to assist you in getting prepared.