



5157A

VITA/TCE Affordable Care Act - Taxpayer Scenarios
Volunteer Income Tax Assistance (VITA) / Tax Counseling for the Elderly (TCE)

2016 RETURNS



Take your VITA/TCE training online at www.irs.gov (keyword: Link & Learn Taxes). Link to the Practice Lab to gain experience using tax software and take the certification test online, with immediate scoring and feedback.



How to Get Technical Updates?

Updates to the volunteer training materials will be contained in Publication 4491X, VITA/TCE Training Supplement. The most recent version can be downloaded at: <https://www.irs.gov/pub/irs-pdf/p4491x.pdf>.

Volunteer Standards of Conduct

VITA/TCE Programs

The mission of the VITA/TCE return preparation programs is to assist eligible taxpayers in satisfying their tax responsibilities by providing **free** tax return preparation. To establish the greatest degree of public trust, volunteers are required to maintain the highest standards of ethical conduct and provide quality service.

All VITA/TCE volunteers (whether paid or unpaid workers) must complete the *Volunteer Standards of Conduct (VSC)* certification and agree to adhere to the VSC by signing Form 13615, *Volunteer Standards of Conduct Agreement*, prior to working at a VITA/TCE site. In addition, return preparers, quality reviewers, and VITA/TCE tax law instructors must certify in tax law prior to signing this form. This form is not valid until the site coordinator, sponsoring partner, instructor, or IRS contact confirms the volunteer's identity and signs and dates the form.

As a volunteer in the VITA/TCE Programs, you must:

1. Follow the Quality Site Requirements (QSR).
2. Not accept payment, solicit donations, or accept refund payments for federal or state tax return preparation.
3. Not solicit business from taxpayers you assist or use the knowledge you gained (their information) about them for any direct or indirect personal benefit for you or any other specific individual.
4. Not knowingly prepare false returns.
5. Not engage in criminal, infamous, dishonest, notoriously disgraceful conduct, or any other conduct deemed to have a negative effect on the VITA/TCE Programs.
6. Treat all taxpayers in a professional, courteous, and respectful manner.

Failure to comply with these standards could result in, but is not limited to, the following:

- Your removal from all VITA/TCE Programs;
- Inclusion in the IRS Volunteer Registry to bar future VITA/TCE activity indefinitely;
- Deactivation of your sponsoring partner's site VITA/TCE EFIN (electronic filing ID number);
- Removal of all IRS products, supplies, loaned equipment, and taxpayer information from your site;
- Termination of your sponsoring organization's partnership with the IRS;
- Termination of grant funds from the IRS to your sponsoring partner; and
- Referral of your conduct for potential TIGTA and criminal investigations.

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Confidentiality Statement:

All tax information you receive from taxpayers in your volunteer capacity is strictly confidential and should not, under any circumstances, be disclosed to unauthorized individuals.



Appendix: Affordable Care Act (ACA) Exercises



Instructions

The purpose of the following examples is to give volunteers an opportunity to practice completing forms and worksheets associated with the Affordable Care Act (ACA) tax provisions. Adequate information is provided to prepare simple tax returns with various health insurance coverage scenarios that you may encounter. Following each scenario are screen shots from the tax preparation software that will allow you to check your work. Note: This publication is posted before software and most tax forms are finalized. In some cases, tax year 2015 screen shots or tax forms are used, but contain 2016 amounts.

Reminders

- All taxpayer names, addresses and Social Security numbers provided in the scenarios are fictitious.
- When entering Social Security numbers (SSNs), replace the Xs as directed, or with any four digits of your choice.
- Use employer identification number (EIN) 622-00-XXXX for all W-2s.
- Complete tax return and intake sheet information is not provided. For the purposes of these exercises, you can ignore incomplete or missing information, or enter sample information of your choice.
- Use your city, state, and ZIP code when completing any forms, unless the notes state otherwise.
- For the purposes of the premium tax credit calculations on Form 8962, use “Other 48 states and DC” so your calculations will match the provided answers.
- For all scenarios, assume that the identity and Social Security cards were checked for all individuals on the intake sheet.

Example 1 – Taxpayer with Partial Year Minimum Essential Coverage (MEC) and Coverage Exemption

Interview Notes

- Greg Clayton is single with no dependents. No one can claim him as a dependent.
- His SSN is 621-00-XXXX
- Greg left his old job on March 15. He was covered under his previous employer through the end of March. He began a new job on June 15th, and immediately became eligible for, and enrolled in, his employer sponsored health care coverage. Both employers withheld Greg’s share of the insurance premium pretax from his paycheck each week.
- Greg was uninsured from April 1 through June 14 of the tax year.
- Greg’s first W-2 shows the following:
 - Box 1 = \$15,200
 - Box 2 = \$1,520
 - Box 12 = \$1,456 with code DD

- Greg's second W-2 shows:
 - Box 1 = \$22,800
 - Box 2 = \$2,280
 - Box 12 = \$2,184 with code DD

Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, personal information, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Greg.
2. Compare your result to the screen shots on the following pages

Form 13614-C (October 2015)		Department of the Treasury - Internal Revenue Service Intake/Interview & Quality Review Sheet				OMB Number 1545-1964	
You will need: <ul style="list-style-type: none"> • Tax Information such as Forms W-2, 1099, 1098. • Social security cards or ITIN letters for all persons on your tax return. • Picture ID (such as valid driver's license) for you and your spouse. 				<ul style="list-style-type: none"> • Please complete pages 1-3 of this form. • You are responsible for the information on your return. Please provide complete and accurate information. • If you have questions, please ask the IRS certified volunteer preparer. 			
Part I – Your Personal Information							
1. Your first name GREG		M.I.	Last name CLAYTON		Telephone number YOUR PHONE #		Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Your spouse's first name		M.I.	Last name		Telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Mailing address 55 CONCORD COURT				Apt #	City YOUR CITY		State YS ZIP code YOUR ZIP
4. Your Date of Birth 7/22/1987		5. Your job title SALES REP		6. Last year, were you:		a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7. Your spouse's Date of Birth		8. Your spouse's job title		9. Last year, was your spouse:		a. Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No	
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input type="checkbox"/> No	
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure							
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
Part II – Marital Status and Household Information							
1. As of December 31 of 2015, were you:		<input checked="" type="checkbox"/> Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)					
		<input type="checkbox"/> Married		a. Did you live with your spouse during any part of the last six months of 2015?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		<input type="checkbox"/> Divorced		b. Was your marriage recognized under the laws of the state(s) you are filing in?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure	
		Date of final decree					

Greg's intake sheet, page 3:

			Page 3											
Check appropriate box for each question in each section														
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C											
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?											
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, is everyone listed on your Form 1095-A being claimed on this tax return?											
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?											

Greg's Form 1095-B from Employer A:

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 GREG CLAYTON	621-00-XXXX	7/22/1987	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>								
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Greg's Form 1095-B from Employer B:

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 GREG CLAYTON	621-00-XXXX	7/22/1987	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>						
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Results – Approaching the ACA

Confirm with Greg the months that he had MEC, and indicate this on Part VI of his intake sheet:

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)						
Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer			J F M A M J J A S O N D	J F M (A M) J J A S O N D		short coverage gap
Spouse			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Results – TaxSlayer ACA Responses

Greg's completed TaxSlayer health insurance input screens are shown below.

Enter the months that Greg had health insurance coverage. Remember that MEC coverage for one day during the month counts for the entire month. He has MEC for January through March and June through December.

Specify Insured Months (GREG CLAYTON)

Please specify the months that GREG CLAYTON had minimum essential coverage

<input checked="" type="checkbox"/> January	<input checked="" type="checkbox"/> February	<input checked="" type="checkbox"/> March
<input type="checkbox"/> April	<input type="checkbox"/> May	<input checked="" type="checkbox"/> June
<input checked="" type="checkbox"/> July	<input checked="" type="checkbox"/> August	<input checked="" type="checkbox"/> September
<input checked="" type="checkbox"/> October	<input checked="" type="checkbox"/> November	<input checked="" type="checkbox"/> December

Back
Continue

Greg qualifies for a short coverage gap exemption for April and May.

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances? Yes No

Back
Continue

Check the box for each month that the exemption applies.

Health Insurance/Exemption

Name of Individual: GREG CLAYTON

Do you have a marketplace-issued certificate for this exemption?: No

Exemption Type: Short gap in coverage

Indicate full year or specify months for which you qualify to take the exemption.

Full Year

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

Cancel Continue

He will not be required to pay any shared responsibility payment.

Health Coverage Exemptions

Name of Individual	Type	
GREG CLAYTON	B	<input type="button" value="Edit"/> <input type="button" value="Delete"/>

Add another exemption

Back Continue

Results – Form 1040, page 2

Greg’s Form 1040, page 2 will not have the “Full-year coverage” box marked and will also not show an amount on the individual responsibility line.

60a Household employment taxes. Schedule H		0
b First-time homebuyer credit repayment. Form 5405		0
61 Health care: individual responsibility	Full-year coverage: <input type="checkbox"/>	0
62 Taxes from	<input type="checkbox"/> Form 8959 <input type="checkbox"/> Form 8960 <input type="checkbox"/>	

Example 2 – Coverage Exemptions

Interview Notes

- Jerome and Judy Baxter are married and file a joint return.
- They have one child, Jana, who they claim as a dependent on their return.
- Jerome's Form W-2 shows the following:
 - Box 1 = \$26,000
 - Box 2 = \$2,000
- Jerome, Judy, and Jana do not have any other income.
- Their Social Security numbers are:
 - Jerome: 623-00-XXXX
 - Judy: 624-00-XXXX
 - Jana: 625-00-XXXX
- Jerome's small employer offered health insurance for the tax year, but Jerome and Judy thought the premium was too expensive. The insurance Jerome was offered met the ACA's definition of an affordable employer coverage offer.
- Jerome and Judy were uninsured for all of 2016.
- They live in a state that did not expand Medicaid coverage to low-income adults.
- Jana was enrolled in Medicaid all year. All children in their state who are under the age of 18 are eligible for Medicaid with household income under 138% of FPL.

Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSNs, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Jerome and his family.
2. Compare your result to the screen shots on the following pages:

Form 13614-C (October 2015)	Department of the Treasury - Internal Revenue Service Intake/Interview & Quality Review Sheet	OMB Number 1545-1964												
<p>You will need:</p> <ul style="list-style-type: none"> • Tax Information such as Forms W-2, 1099, 1098, 1095. • Social security cards or ITIN letters for all persons on your tax return. • Picture ID (such as valid driver's license) for you and your spouse. <p>• Please complete pages 1-3 of this form. • You are responsible for the information on your return. Please provide complete and accurate information. • If you have questions, please ask the IRS-certified volunteer preparer.</p>														
Part I – Your Personal Information														
1. Your first name JEROME	M.I. BAXTER	Last name BAXTER	Telephone number YOUR PHONE #	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
2. Your spouse's first name JUDY	M.I. BAXTER	Last name BAXTER	Telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
3. Mailing address 33 APACHE WAY		Apt #	City YOUR CITY	State YS										
4. Your Date of Birth 07/09/1979	5. Your job title SALES	6. Last year, were you:		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
7. Your spouse's Date of Birth 12/01/1983		8. Your spouse's job title HOMEMAKER		b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
9. Last year, was your spouse:		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		a. Full-time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure		11. Have you or your spouse:		b. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No												
Part II – Marital Status and Household Information														
1. As of December 31, 2015, were you: <input type="checkbox"/> Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)														
<input checked="" type="checkbox"/> Married a. If Yes, Did you get married in 2015? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
<input type="checkbox"/> Divorced Date of final decree _____														
<input type="checkbox"/> Legally Separated Date of separate maintenance agreement _____														
<input type="checkbox"/> Widowed Year of spouse's death _____														
2. List the names below of: • everyone who lived with you last year (other than your spouse) • anyone you supported but did not live with you last year														
If additional space is needed check here <input type="checkbox"/> and list on page 3														
										To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)	
JANA BAXTER	02/04/2015	DAUGHTER	12	YES	YES	S	NO	NO	NO	NO	YES	YES	YES	

Page 3 of the intake sheet:

Check appropriate box for each question in each section				Page 3
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If Yes, Receive an advanced payment from the Marketplace to help pay your monthly health care payments?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?	
Visit http://www.healthcare.gov/ or call 1-800-318-2596 for more information on health insurance options and assistance.				

Results – Approaching the ACA

Complete the volunteer section of the Baxters' intake sheet, Part II:

										To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)	
JANA BAXTER	02/04/2015	DAUGHTER	12	YES	YES	S	NO	NO	NO	NO	YES	YES	YES	
<p>Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at wi.voltax@irs.gov</p>														
Catalog Number 52121E				www.irs.gov				Form 13614-C (Rev. 10-2015)						

Results – Exemption; Medicaid Coverage Gap

Consider the income-based exemptions Jerome and Judy may be eligible to claim. At \$26,000, their income is above the filing threshold, so they cannot claim the exemption on Line 7 of Form 8965.

Because they live in a state that did not expand Medicaid coverage, the Code G exemption will apply if their income is less than 138% of the federal poverty line (FPL). Use the table in Publication 4012, ACA tab, to find the income amount for a family of three at 138% FPL (\$27,724). Jerome and Judy's income (\$26,000) is less than 138% FPL, so they are eligible to claim Code G. Eligibility for affordable employer-sponsored coverage or coverage in the marketplace does not disqualify them from this exemption.

Complete the volunteer section of the Baxter' intake sheet, Part VI:

as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Medicaid coverage gap
Spouse		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Medicaid coverage gap
Dependent	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Covered by Medicaid
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Part VII – Additional Information and Questions Related to the Preparation of Your Return

Results – TaxSlayer ACA Responses

Indicate that Jana was covered by Medicaid for the entire year and Jerome and Judy did not have health insurance coverage for any month during the year:

Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2015? Yes No

Months Insured

Was your entire household insured for all 12 months of 2015?

Please enter the number of months insured for each household member.

Name	Months Insured
JEROME BAXTER	<input type="text" value="0"/>
JUDY BAXTER	<input type="text" value="0"/>
JANA BAXTER	<input type="text" value="12"/>

Jerome had no health insurance coverage for any month:

Specify Insured Months (JEROME BAXTER)
Please specify the months that JEROME BAXTER had minimum essential coverage

<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March
<input type="checkbox"/> April	<input type="checkbox"/> May	<input type="checkbox"/> June
<input type="checkbox"/> July	<input type="checkbox"/> August	<input type="checkbox"/> September
<input type="checkbox"/> October	<input type="checkbox"/> November	<input type="checkbox"/> December

Enter the same information for Judy.

You have determined that Jerome and Judy qualify for a coverage exemption. Complete the remaining questions to claim the exemption for Jerome and Judy on the tax return.

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances? Yes No

Their income is above the filing threshold, so you will not select this box:

Coverage Exemptions
Do either of the following apply to your household?

Are you claiming a hardship exemption because your gross income is below the filing threshold?

In the screen below, indicate that Jerome can claim a coverage exemption because his income is below 138% of FPL and he was a resident of a state that did not expand Medicaid.

Health Insurance/Exemption

Name of Individual

Do you have a marketplace-issued certificate for this exemption?

Exemption Type

Indicate full year or specify months for which you qualify to take the exemption.

Full Year

Make the same entries for Judy.

Health Coverage Exemptions	
Name of Individual	Type
JUDY BAXTER	G
	<input type="button" value="Edit"/>
	<input type="button" value="Delete"/>
JEROME BAXTER	G
	<input type="button" value="Edit"/>
	<input type="button" value="Delete"/>
<input type="button" value="Add"/> Add another exemption	
<input type="button" value="Back"/>	
<input type="button" value="Continue"/>	

Results – Form 8965 Part III

Part III Coverage Exemptions Claimed on Your Return for Individuals. If you and/or a member of your tax household are claiming an exemption on your return, complete Part III.																
	(a) Name of Individual	(b) SSN	(c) Exemption Type	(d) Full Year	(e) Jan	(f) Feb	(g) Mar	(h) Apr	(i) May	(j) June	(k) July	(l) Aug	(m) Sept	(n) Oct	(o) Nov	(p) Dec
8	JEROME BAXTER	623-00-XXXX	G	X												
9	JUDY BAXTER	624-00-XXXX	G	X												

Results – Form 1040 Page 2

On Form 1040, the “Full-year coverage” box is not checked:

61	Health care: individual responsibility (see instructions)	Full-year coverage <input type="checkbox"/>	61
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In this case, each member of the tax household had either coverage or a coverage exemption for each month so there is no individual shared responsibility payment required.

Example 3 – Coverage Exemptions

Interview Notes

- Susan and Lee Parks are married and file a joint return.
- They have two children, Elisabeth and Emilee, whom they claim as dependents on their return.
- Susan's Form W-2 shows the following:
 - Box 1 = \$30,000
 - Box 2 = \$2,000
- Lee's Form W-2 shows the following:
 - Box 1 = \$27,000
 - Box 2 is \$2,700.
- Neither Susan, Lee, nor their children have any other income.
- Their Social Security numbers are:
 - Lee: 613-00-XXXX
 - Susan: 614-00-XXXX
 - Elisabeth: 615-00-XXXX
 - Emilee: 616-00-XXXX
- Lee's employer did not offer health insurance coverage for the tax year.
- Susan purchased self-only coverage under a plan offered by her employer.
- Susan had the option to purchase family coverage under an insurance plan offered by her employer which would have covered Susan, Lee, Elisabeth, and Emilee, at a cost of \$13,140. Susan and Lee could not afford this plan. Lee, Elisabeth and Emilee did not have health insurance coverage all year.
- The Parks don't qualify for any non-income-based coverage exemptions.

Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, dependents, personal information, and income. Then complete the following steps:

1. Determine if this couple is eligible for the affordability exemption. No other exemptions apply.
2. Select the Health Insurance section and answer all the questions pertaining to Susan, Lee, Elisabeth, and Emilee.
3. Compare your result to the screen shots on the following pages.

Form 13614-C (October 2015)	Department of the Treasury - Internal Revenue Service Intake/Interview & Quality Review Sheet	OMB Number 1545-1964											
<p>You will need:</p> <ul style="list-style-type: none"> • Tax Information such as Forms W-2, 1099, 1098. • Social security cards or ITIN letters for all persons on your tax return. • Picture ID (such as valid driver's license) for you and your spouse. <p>• Please complete pages 1-3 of this form. • You are responsible for the information on your return. Please provide complete and accurate information. • If you have questions, please ask the IRS certified volunteer preparer.</p>													
Part I – Your Personal Information													
1. Your first name LEE	M.I.	Last name PARKS	Telephone number YOUR PHONE #	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
2. Your spouse's first name SUSAN	M.I.	Last name PARKS	Telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
3. Mailing address 87 HASTINGS BLVD		Apt #	City YOUR CITY	State YS									
4. Your Date of Birth 06/01/1968		5. Your job title CONSTRUCTION		6. Last year, were you: a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
7. Your spouse's Date of Birth 04/05/1970		8. Your spouse's job title SALES		9. Last year, was your spouse: a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
Part II – Marital Status and Household Information													
1. As of December 31 of 2015, were you: <input type="checkbox"/> Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input checked="" type="checkbox"/> Married a. Did you live with your spouse during any part of the last six months of 2015? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No b. Was your marriage recognized under the laws of the state(s) you are filing in? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure <input type="checkbox"/> Divorced Date of final decree _____ <input type="checkbox"/> Legally Separated Date of separate maintenance agreement _____ <input type="checkbox"/> Widowed Year of spouse's death _____													
2. List the names below of: • everyone who lived with you last year (other than you or your spouse) • anyone you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
To be completed by a Certified Volunteer Preparer													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
ELISABETH PARKS	03/02/2012	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
EMILEE PARKS	09/07/2007	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES

Page 3 of the Parks' intake sheet:

Page 3			
Check appropriate box for each question in each section			
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage? Susan
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input checked="" type="checkbox"/> Form 1095-C
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?

Results – Exemptions; Insurance is Unaffordable

Complete the volunteer section on page 1 of the intake sheet:

If additional space is needed check here <input type="checkbox"/> and list on page 3													
To be completed by a Certified Volunteer Preparer													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
ELISABETH PARKS	03/02/2012	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
EMILEE PARKS	09/07/2007	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
<p>Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at wi.voltax@irs.gov or call toll free</p>													
Catalog Number 52121E				www.irs.gov				Form 13614-C (Rev. 10-2015)					

Form 1095-B for Susan Parks:

Part IV Covered Individuals (Enter the information for each covered individual.)																					
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage																	
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec						
23 SUSAN PARKS	614-00-XXXX	04/05/1970	<input checked="" type="checkbox"/>	<input type="checkbox"/>																	

Form 1095-C for Susan Parks:

Form 1095-C Department of the Treasury Internal Revenue Service	Employer-Provided Health Insurance Offer and Coverage	<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED	OMB No. 1545-2251 2016																		
Part I Employee		Applicable Large Employer Member (Employer)																			
1 Name of employee SUSAN PARKS		2 Social security number (SSN) 614-00-XXXX		7 Name of employer EMPLOYER A				8 Employer identification number (EIN) 62-200XXXX													
3 Street address (including apartment no.) 87 HASTINGS BLVD						9 Street address (including room or suite no.) 1 FIRST AVENUE				10 Contact telephone number YOUR PHONE											
4 City or town YOUR CITY		5 State or province YS		6 Country and ZIP or foreign postal code YOUR ZIP		11 City or town YOUR CITY		12 State or province YS		13 Country and ZIP or foreign postal code YOUR ZIP											
Part II Employee Offer and Coverage											Plan Start Month (Enter 2-digit number):										
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec								
1E																					
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 260	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$								
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C																				
Part III Covered Individuals													<input type="checkbox"/>								
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.																					
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage																	
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec						
17 SUSAN PARKS	614-00-XXXX	04/05/1970	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Susan had coverage all year so you do not need to determine if it was affordable. Next, determine if the coverage available to Lee, Elisabeth and Emilee is considered unaffordable.

The required contribution for Lee, Elisabeth, and Emilee is Susan's share of the cost for family coverage (\$13,140), which is more than 8.13% of their household income (\$57,000 x .0813 = \$4,634). As a result, Lee, Elisabeth, and Emilee are eligible for the exemption for unaffordable coverage for the tax year. Their Affordability Worksheet is completed below:

(A) Affordability Threshold

Enter 8.13% of your household income (see *Household Income*). For this purpose, increase household income by the amount of any premium that is paid through a salary reduction arrangement and excluded from gross income.

\$4634

(B) Required Contribution Amount

For each member of your tax household, enter in the columns provided the annual premium for the first option below that applies to that person. If the premium is the same for the whole year, enter the same value for each month. If the premiums covers only part of the year, use the *Annualized Premium Worksheet* to determine what the annualized premium would be for each month.

Options (use the first that applies to each member of your tax household, including you, for each month):

1. The lowest cost self-only policy offered to each member of your tax household by his or her employer.
2. The lowest cost family policy* offered by your employer or your spouse's employer (if you are filing a joint return).
3. The amount from the Marketplace Coverage Affordability Worksheet.

For each individual, coverage is unaffordable and the individual is exempt if (B), the Required Contribution Amount, is greater than (A), the Affordability Threshold.

Members of your tax household (enter one name per column):	Lee	Elisabeth	Emilee			
Premium for:						
January	13,140	13,140	13,140			
February	13,140	13,140	13,140			
March	13,140	13,140	13,140			
April	13,140	13,140	13,140			
May	13,140	13,140	13,140			
June	13,140	13,140	13,140			
July	13,140	13,140	13,140			
August	13,140	13,140	13,140			
September	13,140	13,140	13,140			
October	13,140	13,140	13,140			
November	13,140	13,140	13,140			
December	13,140	13,140	13,140			

*The policy must cover everyone in your tax household:

- for whom a personal exemption deduction is claimed on your tax return,
- who is not eligible for employer coverage, and
- who does not qualify for another coverage exemption.

After you determine that the taxpayers are eligible for a coverage exemption, complete the volunteer section of the Part VI on the intake sheet:

as, income, marital status or family size changes, to your Marketplace. Reporting changes will help to make sure you are getting the proper amount of advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer Lee		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Spouse Susan	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Employer coverage
Dependent Elisabeth		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Dependent Emilee		X	J F M A M J J A S O N D	J F M A M J J A S O N D	Yes	Coverage unaffordable
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Part VII - Additional Information and Questions Related to the Preparation of Your Return

Results – TaxSlayer ACA Responses

Answer the ACA questions for Susan and Lee as shown below. Because Susan had minimum essential coverage all year, indicate that she was insured for 12 months. Because Lee, Elisabeth and Emilee had no insurance all year, indicate zero months for each.

Months Insured

Was your entire household insured for all 12 months of 2015?

Please enter the number of months insured for each household member.

Name	Months Insured
LEE PARKS	<input type="text" value="0"/>
SUSAN PARKS	<input type="text" value="12"/>
ELISABETH PARKS	<input type="text" value="0"/>
EMILEE PARKS	<input type="text" value="0"/>

Complete this section to claim coverage exemptions for Lee, Elisabeth and Emilee on the tax return.

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances? Yes No

First enter the information for Lee:

Health Insurance/Exemption

Name of Individual

Do you have a marketplace-issued certificate for this exemption?

Exemption Type

Indicate full year or specify months for which you qualify to take the exemption.

Full Year

Then add additional exemptions for Elisabeth and Emilee:

Health Coverage Exemptions

Name of Individual	Type		
LEE PARKS	A	Edit	Delete

Add Add another exemption

Back **Continue**

Results – Health Coverage Exemptions

Health Coverage Exemptions

Name of Individual	Type		
ELISABETH PARKS	A	Edit	Delete
EMILEE PARKS	A	Edit	Delete
LEE PARKS	A	Edit	Delete

Add Add another exemption

Back **Continue**

Results – Form 8965 Part III

Part III Coverage Exemptions Claimed on Your Return for Individuals. If you and/or a member of your tax household are claiming an exemption on your return, complete Part III.

	(a) Name of Individual	(b) SSN	(c) Exemption Type	(d) Full Year	(e) Jan	(f) Feb	(g) Mar	(h) Apr	(i) May	(j) June	(k) July	(l) Aug	(m) Sept	(n) Oct	(o) Nov	(p) Dec
8	LEE PARKS	613-00-XXXX	A	X												
9	ELISABETH PARKS	615-00-XXXX	A	X												
10	EMILEE PARKS	616-00-XXXX	A	X												

Results – Form 1040 Page 2

On Form 1040, the “Full-year coverage” box is not checked:

61 Health care: individual responsibility Full-year coverage:

In this case, each member of the tax household had either coverage or a coverage exemption for every month so there is no individual shared responsibility payment required.

Example 4 – Affordability Exemptions – Marketplace Coverage

Interview Notes

- Edward and Julia Fulton are married and file a joint return. Their SSNs are:
 - Edward: 617-00-XXXX
 - Julia: 618-00-XXXX
- The Fultons have a dependent son, Sam. Sam worked part-time and earned enough that he was required to file a tax return this year. Sam's MAGI is \$6,900. Sam's SSN is 619-00-XXXX.
- Julia and Edward did not have minimum essential coverage for any month during the tax year. Edward and Julia mention that they looked into purchasing coverage through the Marketplace, but felt that the premiums were too expensive.
- Sam was covered all year by a government-sponsored Children's Health Plan.
- Edward's Form W-2 shows:
 - Box 1 = \$16,280
 - Box 2 = \$1,628
- Julia's W-2 shows:
 - Box 1 = \$17,000
 - Box 2 = \$0
- Edward and Julia had no other income.

Directions

Explain that if their premium costs for Marketplace coverage is more than a certain percentage of their income, they would be eligible for an exemption from the SRP. Complete the worksheets in the Form 8965 Instructions to see if Edward and Julia qualify for the affordability exemption. Edward and Julia were not offered insurance coverage through their employers, so you'll need to complete two worksheets:

1. The Affordability Worksheet
2. The Marketplace Coverage Affordability Worksheet.

Form 13614-C (October 2015)	Department of the Treasury - Internal Revenue Service Intake/Interview & Quality Review Sheet	OMB Number 1545-1964											
You will need: <ul style="list-style-type: none"> • Tax Information such as Forms W-2, 1099, 1098. • Social security cards or ITIN letters for all persons on your tax return. • Picture ID (such as valid driver's license) for you and your spouse. 													
Please complete pages 1-3 of this form. You are responsible for the information on your return. Please provide complete and accurate information. If you have questions, please ask the IRS certified volunteer preparer.													
Part I – Your Personal Information													
1. Your first name EDWARD	M.I. FULTON	Last name FULTON	Telephone number YOUR PHONE #	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
2. Your spouse's first name JULIA	M.I.	Last name FULTON	Telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
3. Mailing address 456 STONEHILL RD		Apt #	City YOUR CITY	State YS									
4. Your Date of Birth 06/01/1978		5. Your job title MANAGER	6. Last year, were you:										
		b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
7. Your spouse's Date of Birth 01/06/1979		8. Your spouse's job title CUSTOMER SERVICE REP		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		9. Last year, was your spouse:		a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
		b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you or your spouse:													
a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
Part II – Marital Status and Household Information													
1. As of December 31 of 2015, were you:													
<input type="checkbox"/> Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)													
<input checked="" type="checkbox"/> Married a. Did you live with your spouse during any part of the last six months of 2015? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
b. Was your marriage recognized under the laws of the state(s) you are filing in? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure													
<input type="checkbox"/> Divorced Date of final decree _____													
<input type="checkbox"/> Legally Separated Date of separate maintenance agreement _____													
<input type="checkbox"/> Widowed Year of spouse's death _____													
2. List the names below of:													
• everyone who lived with you last year (other than you or your spouse)													
• anyone you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
To be completed by a Certified Volunteer Preparer													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example, son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a) SAM FULTON	(b) 05/19/1998	(c) SON	(d) 12	(e) YES	(f) YES	(g) S	(h) YES	(i) NO					

Check appropriate box for each question in each section				Page 3
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?	
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?	

Results – Affordability Worksheet

Complete the top of the Affordability Worksheet to determine the Affordability Threshold of the Household Income. Include the MAGI for a dependent, such as Sam, whose income exceeds the filing threshold.

The calculation is: \$40,180 x .0813 (affordability threshold for 2016) = \$3,267.

Affordability Worksheet

Use this worksheet to determine whether coverage for each individual in your tax household is unaffordable. If you or another member of your tax household isn't eligible for employer-sponsored coverage, use the [Marketplace Coverage Affordability Worksheet](#) to figure the required contribution for that individual. An individual is exempt for any month in which (B), the Required Contribution, is more than (A), the Affordability Threshold.

(A) Affordability Threshold

Enter 8.13% of your household income (see *Household income*). For this purpose, increase household income by the amount of any premium that is paid through a salary reduction arrangement and excluded from gross income.

\$3,267

(B) Required Contribution Amount

Since Edward and Julia are not eligible for employer-sponsored coverage, they need to use the Marketplace Coverage Affordability Worksheet. Visit www.healthcare.gov to find the figures they will need to complete this worksheet:

- Remember to use their ages at the start of the tax year, since the first month they did not have coverage was January.
- Assume they live in zip code 31405 (Chatham County, GA) and do not use tobacco.
- Look up the lowest cost bronze plan for Edward, Julia and Sam. For this example, Sam is included in the calculation for the lowest cost bronze plan since he does not have an offer of employer coverage. Enter this amount on line 1 of the worksheet.
- Then look up the second lowest cost silver plan (SCLSP) for Edward and Julia. Do not include Sam in this quote because he has government-sponsored coverage. Enter this figure on line 10.

 Do not complete this worksheet unless you were instructed to do so in the Affordability Worksheet.	
1. Enter the monthly premium for the lowest cost bronze plan that covers everyone in your tax household for whom a personal exemption deduction is claimed, who is not eligible for employer coverage, and who does not qualify for another coverage exemption for the month. To find the lowest cost bronze plan go to the Marketplace for your area	\$492
2. Enter your household income (see Household income)	\$40,180
3. Enter the total of all nontaxable social security benefits received by you, your spouse, and each claimed dependent who must file a tax return*	
4. Add lines 2 and 3	\$40,180
5. Enter the federal poverty line for the number of individuals in your tax household less any dependents not claimed. See the instructions for Form 8962, line 4	\$20,090
6. Divide line 4 by line 5. If the result (without rounding) is less than 1.0 or more than 4.0, skip lines 7 through 10 and enter -0- on line 11.	2.0
7. Multiply line 6 by 100 and round to the nearest whole number. Enter the applicable figure for the result from the table in the instructions for Form 8962, line 7	0.0641
8. Multiply line 4 by line 7	\$2,576
9. Divide line 8 by 12.0	\$215
10. Enter the monthly premium for the second lowest cost silver plan premium that covers everyone in your tax household for whom a personal exemption deduction is claimed, who is not eligible for minimum essential coverage (other than coverage in the individual market), and who does not qualify for another coverage exemption for the month. To find the second lowest cost silver plan go the Marketplace for your area	\$450
11. Subtract line 9 from line 10	\$235
12. Subtract line 11 from line 1. If zero or less, enter -0-. This is the individual's required contribution for the month	\$257
13. Is the individual eligible for this coverage for every month of the year?	
<input checked="" type="checkbox"/> Yes. Multiply line 12 by 12.0. This is the annualized premium. Enter this amount in the space for every month on the Affordability Worksheet	\$3,084
<input type="checkbox"/> No. Use the Annualized Premium Worksheet to determine what the annualized premium would be for each month the individual was eligible for the coverage being tested. Enter the annualized premium in the space for the appropriate months on the Affordability Worksheet	

Compare the annualized premium from line 13 of the Marketplace Coverage Affordability Worksheet to the Affordability Threshold. Because the annualized premium is lower than the 8.13% threshold, Edward and Julia can't claim the affordability exemption.

(B) Required Contribution Amount
 For each member of your tax household, enter in the columns provided the annual premium for the first option below that applies to that person. If the premium is the same for the whole year, enter the same value for each month. If the premiums covers only part of the year, use the [Annualized Premium Worksheet](#) to determine what the annualized premium would be for each month.

Options (use the first that applies to each member of your tax household, including you, for each month):

1. The lowest cost self-only policy offered to each member of your tax household by his or her employer.
2. The lowest cost family policy* offered by your employer or your spouse's employer (if you are filing a joint return).
3. The amount from the Marketplace Coverage Affordability Worksheet.

For each individual, coverage is unaffordable and the individual is exempt if (B), the Required Contribution Amount, is greater than (A), the Affordability Threshold.

Members of your tax household (enter one name per column):	Edward	Julia			
Premium for:					
January	\$3,084	\$3,084			
February	\$3,084	\$3,084			
March	\$3,084	\$3,084			
April	\$3,084	\$3,084			
May	\$3,084	\$3,084			
June	\$3,084	\$3,084			
July	\$3,084	\$3,084			
August	\$3,084	\$3,084			
September	\$3,084	\$3,084			
October	\$3,084	\$3,084			
November	\$3,084	\$3,084			
December	\$3,084	\$3,084			

*The policy must cover everyone in your tax household:

- for whom a personal exemption deduction is claimed on your tax return,
- who is not eligible for employer coverage, and
- who does not qualify for another coverage exemption.

Complete Part VI of their intake sheet, indicating that Edward and Julia are not eligible for a coverage exemption.

advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer Edward		X	J F M A M J J A S O N D	J F M A M J J A S O N D		No Exemption
Spouse Julia		X	J F M A M J J A S O N D	J F M A M J J A S O N D		No Exemption
Dependent Sam	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Covered by CHP
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Part VII – Additional Information and Questions Related to the Preparation of Your Return

1. Presidential Election Campaign Fund (If you check a box, your tax or refund will not change)

Because Edward and Julia did not have MEC were not eligible for an exemption, they must make an individual shared responsibility payment (SRP). Complete their return in the next example.

Example 5 – Shared Responsibility Payment

For this scenario, use the same facts as Example 4.

Since Edward and Julia didn't have health insurance coverage for any month of the year and weren't eligible for an exemption, they must make a shared responsibility payment.

Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, dependents, personal information, and income. Then complete the following steps:

1. Complete the Health Insurance section of Edward and Julia's tax return.
2. Find the shared responsibility payment on the tax return and compare your results with the screen shots below.

Results – TaxSlayer ACA Responses

Edward and Julia's completed Health Insurance section is shown below. Neither spouse had minimum essential coverage for any month, so you will indicate zero months insured for both taxpayer and spouse. Sam had full coverage all year, so you will indicate 12 months of coverage for him.

Months Insured

Was your entire household insured for all 12 months of 2015?

Please enter the number of months insured for each household member.

Name	Months Insured
EDWARD FULTON	<input type="text" value="0"/>
JULIA FULTON	<input type="text" value="0"/>
SAM FULTON	<input type="text" value="12"/>

Since you previously determined that Edward and Julia were not eligible for the affordability exemption or any other exemption, enter it here:

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances? Yes No

Because Sam's income exceeded the filing threshold, his MAGI is included in household income when calculating Edward and Julia's shared responsibility payment.

Dependents' Modified AGI (if filing requirement)

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 4; and Form 1040NR, line 37 \$6900

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b \$

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18 \$

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b \$

← Back
✓ Continue

Results – Form 1040 Page 2

The shared responsibility payment will carry over to Edward and Julia's Form 1040, page 2, shown below:

60a Household employment taxes. Schedule H	0
b First-time homebuyer credit repayment. Form 5405	0
61 Health care: individual responsibility Full-year coverage: <input type="checkbox"/>	1390
62 Taxes from <input type="checkbox"/> Form 8959 <input type="checkbox"/> Form 8960 <input type="checkbox"/>	



Example 6 – Premium Tax Credit with Advance Credit Payments

Interview Notes

- Sheryl Graves has two children she claims as dependents, Trina and Travis, who live with her all year. She divorced in 2010. Sheryl pays all the costs of keeping up the home. Their SSNs are:
 - Sheryl: 605-00-XXXX
 - Trina: 606-00-XXXX
 - Travis: 607-00-XXXX
- Sheryl's mother, Monique Floyd, also lives with her. Sheryl provides over half of Monique's support and claims her as a dependent. Monique's SSN is 608-00-XXXX. Her only income for the tax year is \$4,500 received from Social Security and she was covered by Medicare all year.
- Sheryl's Form W-2 shows:
 - Box 1 = \$36,429
 - Box 2 = \$1,026
- Sheryl had no other income or deductions.
- Sheryl's employer does not offer health insurance coverage. She purchased minimum essential coverage for herself and her children through the Marketplace. They were covered for the entire year. Sheryl received the benefit of advance payments of the premium tax credit to help with the cost of her insurance premiums.

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSN, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Sheryl and her family
2. Compare your result to the screen shots on the following pages

Form 13614-C (October 2015)		Department of the Treasury - Internal Revenue Service Intake/Interview & Quality Review Sheet				OMB Number 1545-1964							
You will need: <ul style="list-style-type: none"> • Tax Information such as Forms W-2, 1099, 1098. • Social security cards or ITIN letters for all persons on your tax return. • Picture ID (such as valid driver's license) for you and your spouse. 				<ul style="list-style-type: none"> • Please complete pages 1-3 of this form. • You are responsible for the information on your return. Please provide complete and accurate information. • If you have questions, please ask the IRS certified volunteer preparer. 									
Part I - Your Personal Information													
1. Your first name SHERYL		M.I.	Last name GRAVES		Telephone number YOUR PHONE #		Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						
2. Your spouse's first name		M.I.	Last name		Telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. Mailing address 321 MARTIN ROAD				Apt #	City YOUR CITY		State YS ZIP code YOUR ZIP						
4. Your Date of Birth 06/17/1979		5. Your job title CLERK		6. Last year, were you:		a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
7. Your spouse's Date of Birth		8. Your spouse's job title		9. Last year, was your spouse:		a. Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No							
				b. Totally and permanently disabled <input type="checkbox"/> Yes <input type="checkbox"/> No		c. Legally blind <input type="checkbox"/> Yes <input type="checkbox"/> No							
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you or your spouse: a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
Part II - Marital Status and Household Information													
1. As of December 31 of 2015, were you:													
<input type="checkbox"/> Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)													
<input type="checkbox"/> Married a. Did you live with your spouse during any part of the last six months of 2015? <input type="checkbox"/> Yes <input type="checkbox"/> No													
b. Was your marriage recognized under the laws of the state(s) you are filing in? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure													
<input checked="" type="checkbox"/> Divorced Date of final decree 4/27/2010													
<input type="checkbox"/> Legally Separated Date of separate maintenance agreement _____													
<input type="checkbox"/> Widowed Year of spouse's death _____													
2. List the names below of: • everyone who lived with you last year (other than you or your spouse) • anyone you supported but did not live with you last year													
If additional space is needed check here <input type="checkbox"/> and list on page 3													
To be completed by a Certified Volunteer Preparer													
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
TRINA GRAVES	03/01/1999	DAUGHTER	12	YES	YES	S	YES	NO					
TRAVIS GRAVES	12/25/2000	SON	12	YES	YES	S	YES	NO					
MONIQUE FLOYD	05/05/1944	MOTHER	12	YES	YES	S	NO	NO					

Sheryl's intake sheet, page 3:

Check appropriate box for each question in each section			Page 3											
Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input checked="" type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?											
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?											
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?											

Monique Floyd's Form 1095-B:

Part IV Covered Individuals (Enter the information for each covered individual(s).)															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered at 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 Monique Floyd	608-00-XXXX	05/05/1944	<input checked="" type="checkbox"/>	<input type="checkbox"/>											

Part I Recipient Information

1 Marketplace identifier XXXXX	2 Marketplace-assigned policy number XXXXXX	3 Policy issuer's name XXXXXXXXXXXX
4 Recipient's name SHERYL GRAVES	5 Recipient's SSN 605-00-XXXX	6 Recipient's date of birth 05/17/1979
7 Recipient's spouse's name	8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date 01/01/2016	11 Policy termination date 12/31/2016	12 Street address (including apartment no.) 321 MARTIN ROAD
13 City or town YOUR CITY	14 State or province YOUR STATE	15 Country and ZIP or foreign postal code YOUR ZIP

Part II Covered Individuals

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16	SHERYL GRAVES	605-00-XXXX	05/17/1979	01/01/2016	12/31/2016
17	TRINA GRAVES	606-00-XXXX	03/01/1999	01/01/2016	12/31/2016
18	TRAVIS GRAVES	607-00-XXXX	12/25/2000	01/01/2016	12/31/2016
19					
20					

Part III Coverage Information

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January	\$587.00	\$774.00	\$492.00
22 February	\$587.00	\$774.00	\$492.00
23 March	\$587.00	\$774.00	\$492.00
24 April	\$587.00	\$774.00	\$492.00
25 May	\$587.00	\$774.00	\$492.00
26 June	\$587.00	\$774.00	\$492.00
27 July	\$587.00	\$774.00	\$492.00
28 August	\$587.00	\$774.00	\$492.00
29 September	\$587.00	\$774.00	\$492.00
30 October	\$587.00	\$774.00	\$492.00
31 November	\$587.00	\$774.00	\$492.00
32 December	\$587.00	\$774.00	\$492.00
33 Annual Totals	\$7,044.00	\$9,288.00	\$5,904.00

Results – Approaching the ACA

Complete the volunteer section of Sheryl's intake sheet on page 1:

everyone who lives with you last year (other than you or your spouse)
 anyone you supported but did not live with you last year

If additional space is needed, check here and list on page 3

									To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yyyy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
TRINA GRAVES	03/01/1999	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
TRAVIS GRAVES	12/25/2000	SON	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
MONIQUE FLOYD	05/05/1944	MOTHER	12	YES	YES	S	NO	NO	NO	NO	YES	YES	YES

Volunteers are trained to provide high quality service and uphold the highest ethical standards.
 To report unethical behavior to the IRS, email us at wi.voltax@irs.gov or call toll free

Catalog Number 52121E www.irs.gov Form 13614-C (Rev. 10-2015)

Complete Part VI of Sheryl's intake sheet after confirming her insurance coverage:

as, income, marital status or family size changes, to your insurance coverage. Reporting changes will help to make sure you are getting the proper amount of advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer Sheryl	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Spouse			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent Trina	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent Travis	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent Monique	X		J F M A M J J A S O N D	J F M A M J J A S O N D		Medicare
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Part VII - Additional Information and Questions Related to the Preparation of Your Return

Sheryl's completed Health Insurance section is shown below. Because Sheryl, Trina, and Travis all had minimum essential coverage all year purchased through the Marketplace, select yes to the following question:

Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? Yes No

Because Sheryl, Trina, Travis all had minimum essential coverage all year purchased through the Marketplace and Monique was covered by Medicare all year, indicate the entire household was insured for all 12 months:

Months Insured

Was your entire household insured for all 12 months of 2015?

Enter the information from Sheryl's Form 1095-A:

Advanced Premium Tax Credit (1095-A)

Did you receive a 1095-A statement or any Premium Tax Credits to assist you in paying for your health care for 2015?

Do all Forms 1095-A include coverage for January through December, with no changes in monthly amounts?

Please enter your annual Advance Premium Tax Credit information

Premium Amount (Form 1095-A, line 33A)

Annual Premium Amount of SLCS (Form 1095-A, line 33B)

Annual Advance Payment of PTC (Form 1095-A, line 33C)

You do not need to enter an amount for the dependents' modified AGI because none of Sheryl's dependents were required to file a return.

Dependents' Modified AGI

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 3; and Form 1040NR, line 37

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

Sheryl is not eligible for any coverage exemptions:

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances? Yes No

Results – Form 1040, page 2

The software will check the "Full-year coverage" box to indicate that everyone listed on the ACA worksheet had insurance all year.

60a Household employment taxes. Schedule H	<input type="text" value="0"/>
b First-time homebuyer credit repayment. Form 5405	<input type="text" value="0"/>
61 Health care: individual responsibility <input type="checkbox"/> Form 8959 <input type="checkbox"/> Form 8960 <input checked="" type="checkbox"/> Full-year coverage:	<input type="text" value="0"/>
62 Taxes from <input type="checkbox"/> Form 8959 <input type="checkbox"/> Form 8960 <input type="checkbox"/>	

There is no amount on the individual responsibility line because all members of the tax household had full year coverage.

Results – Premium Tax Credit Form 8962

Form 8962 Department of the Treasury Internal Revenue Service Name shown on your return SHERYL GRAVES	Premium Tax Credit (PTC) ▶ Attach to Form 1040, 1040A, or 1040NR. ▶ Information about Form 8962 and its separate instructions is at www.irs.gov/form8962 .	OMB No. 1545-0074 2016 Attachment Sequence No. 73
Your social security number 605-00-XXXX		You cannot claim the PTC if your filing status is married filing separately unless you are eligible for an exception (see instructions). If you qualify, check the box. <input type="checkbox"/>

Part I Annual and Monthly Contribution Amount			
1	Tax family size. Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d		4
2a	Modified AGI. Enter your modified AGI (see instructions)	36429	2b
b Enter the total of your dependents' modified AGI (see instructions)			
3	Household income. Add the amounts on lines 2a and 2b		36429
4	Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3 (see instructions). Check the appropriate box for the federal poverty table used. a <input type="checkbox"/> Alaska b <input type="checkbox"/> Hawaii c <input type="checkbox"/> Other 48 states and DC		24250
5	Household income as a percentage of federal poverty line (see instructions)		150 %
6	Did you enter 401% on line 5? (See instructions if you entered less than 100%.) <input checked="" type="checkbox"/> No. Continue to line 7. <input type="checkbox"/> Yes. You are not eligible to receive PTC. If advance payment of the PTC was made, see the instructions for how to report your excess advance PTC repayment amount.		
7	Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions		.0407
8a	Annual contribution amount. Multiply line 3 by line 7	1483	8b
b Monthly contribution amount. Divide line 8a by line 12. Round to whole dollar amount			124

Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit						
9 Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage (see instructions)? <input type="checkbox"/> Yes. Skip to Part IV, Shared Policy Allocation, or Part V, Alternative Calculation for Year of Marriage. <input checked="" type="checkbox"/> No. Continue to line 10.						
10 See the instructions to determine if you can use line 11 or must complete lines 12 through 23. <input type="checkbox"/> Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12–23 and continue to line 24. <input checked="" type="checkbox"/> No. Continue to lines 12–23. Compute your monthly PTC and continue to line 24.						
Annual Calculation	(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)	(b) Annual applicable SLCSP premium (Form(s) 1095-A, line 33B)	(c) Annual contribution amount (line 8a)	(d) Annual maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Annual premium tax credit allowed (smaller of (a) or (d))	(f) Annual advance payment of PTC (Form(s) 1095-A, line 33C)
11 Annual Totals	7044	9288	1483	7805	7044	5904
Monthly Calculation	(a) Monthly enrollment premiums (Form(s) 1095-A, lines 21–32, column A)	(b) Monthly applicable SLCSP premium (Form(s) 1095-A, lines 21–32, column B)	(c) Monthly contribution amount (amount from line 8b) or alternative marriage	(d) Monthly maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Monthly premium tax credit allowed (smaller of (a) or (d))	(f) Monthly advance payment of PTC (Form(s) 1095-A, lines 21–32, column C)
21 October						
22 November						
23 December						
24	Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here					7044
25	Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here					5904
26	Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Form 1040, line 69; Form 1040A, line 45; or Form 1040NR, line 65. If you elected the alternative calculation for marriage, enter zero. If line 24 equals line 25, enter zero. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27					1140
Part III Repayment of Excess Advance Payment of the Premium Tax Credit						
27	Excess advance payment of PTC. If line 25 is greater than line 24, subtract line 25 from line 24. Enter the difference here					
28	Repayment limitation (see instructions)					

TIP

Column C of the 1095-A is entered in Column F of Form 8962.

Results – Form 1040, page 2

68 American opportunity credit. Form 8863	0
69 Net premium tax credit. Form 8962	1140
70 Amount paid with request for extension of time to file	0

Example 7 – Premium Tax Credit with Advance Payments for Part-Year Coverage

Interview Notes

- Charles and Shay Baldwin are married with two dependent children, Nathaniel and Karly, who live with them all year. Their SSNs are:
 - Charles: 609-00-XXXX
 - Shay: 610-00-XXXX
 - Nathaniel: 611-00-XXXX
 - Karly: 612-00-XXXX
- Charles' Form W-2 shows:
 - Box 1 = \$33,500
 - Box 2 = \$1,820
- Shay's W-2 shows:
 - Box 1 = \$17,750
 - Box 2 = \$1,153
- Charles' and Shay's employers do not offer health insurance coverage. In early March, Charles enrolled in a plan through the Marketplace that covered him, Shay, and both children with an effective date of April 1. He selected the second lowest cost silver plan. They received the benefit of advance payments of the premium tax credit for their coverage. During the year, Charles received an unexpected raise in pay. They did not notify the Marketplace. The family has no other income or deductions.
- They received a marketplace exemption for January, February, and March.
 - Charles' ECN is A23BC5
 - Shay's ECN is A34BC6
 - Nathaniel's ECN is A45BC7
 - Karly's ECN is A56BC8

Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using Practice Lab or TaxSlayer software. Enter the SSNs, filing status, personal information, dependents, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Charles, Shay, and their family.
2. Compare your result to the screen shots on the following pages

You will need:

- Tax information such as Forms W-2, 1099, 1098.
- Social security cards or ITIN letters for all persons on your tax return.
- Picture ID (such as valid driver's license) for you and your spouse.

• Please complete pages 1-3 of this form.

- You are responsible for the information on your return. Please provide complete and accurate information.
- If you have questions, please ask the IRS certified volunteer preparer.

Part I - Your Personal Information

1. Your first name CHARLES	M.I.	Last name BALDWIN	Telephone number YOUR PHONE #	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
2. Your spouse's first name SHAY	M.I.	Last name BALDWIN	Telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
3. Mailing address 775 BANKS ST		Apt #	City YOUR CITY	State YS ZIP code YOUR ZIP
4. Your Date of Birth 12/03/1981	5. Your job title CUSTOMER SERVICE REP		6. Last year, were you: a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
7. Your spouse's Date of Birth 06/10/1985		8. Your spouse's job title CASHIER		b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
9. Last year, was your spouse:		a. Full time student <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10. Can anyone claim you or your spouse on their tax return? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure		b. Totally and permanently disabled <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No c. Legally blind <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
11. Have you or your spouse:		a. Been a victim of identity theft? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No b. Adopted a child? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		

Part II - Marital Status and Household Information

1. As of December 31 of 2015, were you:

Single (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)

Married a. Did you live with your spouse during any part of the last six months of 2015? Yes No

b. Was your marriage recognized under the laws of the state(s) you are filing in? Yes No Unsure

Divorced Date of final decree _____

Legally Separated Date of separate maintenance agreement _____

Widowed Year of spouse's death _____

2. List the names below of:

- everyone who lived with you last year (other than you or your spouse)
- anyone you supported but did not live with you last year

If additional space is needed check here and list on page 3

Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yyyy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of US, Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	To be completed by a Certified Volunteer Preparer				
									Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a) NATHANIEL BALDWIN	(b) 04/04/2004	(c) SON	(d) 12	(e) YES	(f) YES	(g) S	(h) YES	(i) NO					
KARLY BALDWIN	04/29/2006	DAUGHTER	12	YES	YES	S	YES	NO					

Page 3 of the intake sheet:

Page 3

Check appropriate box for each question in each section

Yes	No	Unsure	Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	1. (B) Have health care coverage?
<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	2. (B) Receive one or more of these forms? (Check the box) <input type="checkbox"/> Form 1095-B <input type="checkbox"/> Form 1095-C
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3. (A) Have coverage through the Marketplace (Exchange)? [Provide Form 1095-A]
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	4. (B) Have an exemption granted by the Marketplace?

Visit www.healthcare.gov or call 1-800-318-2596 for more information on health insurance options and assistance.

Part I Recipient Information

1 Marketplace identifier XXXXX	2 Marketplace-assigned policy number XXXXX	3 Policy issuer's name XXXXXXXXXXXX
4 Recipient's name CHARLES BALDWIN	5 Recipient's SSN 609-00-XXXX	6 Recipient's date of birth 12/03/1981
7 Recipient's spouse's name SHAY BALDWIN	8 Recipient's spouse's SSN 610-00-XXXX	9 Recipient's spouse's date of birth 06/10/1985
10 Policy start date 04/01/2016	11 Policy termination date 12/31/2016	12 Street address (including apartment no.) 775 BANKS ST
13 City or town YOUR CITY	14 State or province YOUR STATE	15 Country and ZIP or foreign postal code YOUR ZIP

Part II Covered Individuals

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16	CHARLES BALDWIN	609-00-XXXX	12/03/1981	04/01/2016	12/31/2016
17	SHAY BALDWIN	610-00-XXXX	06/10/1985	04/01/2016	12/31/2016
18	NATHANIEL BALDWIN	611-00-XXXX	04/04/2004	04/01/2016	12/31/2016
19	KARLY BALDWIN	612-00-XXXX	04/29/2006	04/01/2016	12/31/2016
20					

Part III Coverage Information

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			
24 April	\$789.00	\$789.00	\$607.00
25 May	\$789.00	\$789.00	\$607.00
26 June	\$789.00	\$789.00	\$607.00
27 July	\$789.00	\$789.00	\$607.00
28 August	\$789.00	\$789.00	\$607.00
29 September	\$789.00	\$789.00	\$607.00
30 October	\$789.00	\$789.00	\$607.00
31 November	\$789.00	\$789.00	\$607.00
32 December	\$789.00	\$789.00	\$607.00
33 Annual Totals	\$7,101.00	\$7,101.00	\$5,463.00

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60703Q

Form **1095-A** (2016)

Results – Approaching the ACA

Complete the volunteer section of the Baldwins' intake sheet, Part II:

everyone who lived with you last year (other than you or your spouse)
 anyone you supported but did not live with you last year

If additional space is needed check here and list on page 3

									To be completed by a Certified Volunteer Preparer				
Name (first, last) Do not enter your name or spouse's name below	Date of Birth (mm/dd/yyyy)	Relationship to you (for example: son, daughter, parent, none, etc)	Number of months lived in your home last year	US Citizen (yes/no)	Resident of U.S., Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/15 (S/M)	Full-time Student last year (yes/no)	Totally and Permanently Disabled (yes/no)	Is this person a qualifying child/relative of any other person? (yes/no)	Did this person provide more than 50% of his/her own support? (yes/no)	Did this person have less than \$4,000 of income? (yes/no)	Did the taxpayer(s) provide more than 50% of support for this person? (yes/no/N/A)	Did the taxpayer(s) pay more than half the cost of maintaining a home for this person? (yes/no)
(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)	(i)					
NATHANIEL BALDWIN	04/04/2004	SON	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
KARLY BALDWIN	04/29/2006	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES

Volunteers are trained to provide high quality service and uphold the highest ethical standards.
 To report unethical behavior to the IRS, email us at wi.voltax@irs.gov or call toll free

Catalog Number 52121E www.irs.gov Form 13614-C (Rev. 10-2015)

Complete the volunteer section of the Baldwins' intake sheet, Part VI:

advance payments.

To be Completed by a Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)

Name (List dependents in the same order as in Part II)	MEC Entire Year	No MEC	Part Year MEC (mark months with coverage)	Exemption (mark months exemptions applies)	Exemption All Year	Notes
Taxpayer Charles			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Spouse Shay			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent Nathaniel			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent Karly			J F M A M J J A S O N D	J F M A M J J A S O N D		Marketplace
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		
Dependent			J F M A M J J A S O N D	J F M A M J J A S O N D		

Part VII – Additional Information and Questions Related to the Preparation of Your Return

Charles and Shay's completed Health Insurance section is shown below. Indicate that Charles, Shay, Nathaniel and Karly all had minimum essential coverage purchased through the Marketplace from April through December:

Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? Yes No

Months Insured

Was your entire household insured for all 12 months of 2015?

Please enter the number of months insured for each household member.

Name	Months Insured
CHARLES BALDWIN	<input type="text" value="9"/> <input type="button" value="v"/>
SHAY BALDWIN	<input type="text" value="9"/> <input type="button" value="v"/>
NATHANIEL BALDWIN	<input type="text" value="9"/> <input type="button" value="v"/>
KARLY BALDWIN	<input type="text" value="9"/> <input type="button" value="v"/>

Indicate the months Charles had health insurance coverage. Do the same for Shay, Nathaniel, and Karly.

Specify Insured Months (CHARLES BALDWIN)

Please specify the months that CHARLES BALDWIN had minimum essential coverage

<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March
<input checked="" type="checkbox"/> April	<input checked="" type="checkbox"/> May	<input checked="" type="checkbox"/> June
<input checked="" type="checkbox"/> July	<input checked="" type="checkbox"/> August	<input checked="" type="checkbox"/> September
<input checked="" type="checkbox"/> October	<input checked="" type="checkbox"/> November	<input checked="" type="checkbox"/> December

Enter the information from the Form 1095-A:

Advanced Premium Tax Credit (1095-A)

Did you receive a 1095-A statement or any Premium Tax Credits to assist you in paying for your health care for 2015?

Do all Forms 1095-A include coverage for January through December, with no changes in monthly amounts?

Please enter your monthly Advance Premium Tax Credit information

Month	Monthly Premium Amount (Form 1095-A, Part III, Column A)	Monthly Premium Amount of SLCS (Form 1095-A, Part III, Column B)	Monthly Advance Payment of PTC (Form 1095-A, Part III, Column C)
January	\$	\$	\$
February	\$	\$	\$
March	\$	\$	\$
April	\$ 789	\$ 789	\$ 607
May	\$ 789	\$ 789	\$ 607
June	\$ 789	\$ 789	\$ 607
July	\$ 789	\$ 789	\$ 607
August	\$ 789	\$ 789	\$ 607
September	\$ 789	\$ 789	\$ 607
October	\$ 789	\$ 789	\$ 607
November	\$ 789	\$ 789	\$ 607
December	\$ 789	\$ 789	\$ 607

Dependents' Modified AGI

Enter the AGI for your dependents from Form 1040, line 38; Form 1040A, line 22; Form 1040EZ, line 3; and Form 1040NR, line 37

Enter any tax-exempt interest for your dependents from Form 1040, line 8b; Form 1040A, line 8b; Form 1040EZ, the amount written to the left of the line 2 entry space; and Form 1040NR, line 9b

Enter any amounts for your dependents from Form 2555, lines 45 and 50, and Form 2555-EZ, line 18

Enter for each of your dependents the difference, if any, between Form 1040, lines 20a and 20b; and Form 1040A, lines 14a and 14b

Back

Continue

The dependents did not have any income or filing requirement.

Each family member received an exemption from the Marketplace for the months when they did not have health coverage:

Do you qualify for Health Care Exemptions?

Did you receive an exemption certificate from a marketplace, or qualify for exemptions due to circumstances?

Yes No

Back

Continue

Their exemptions are not income-based, so you will not check this box:

Coverage Exemptions

Do either of the following apply to your household?

Are you claiming a hardship exemption because your gross income is below the filing threshold?

Back

Continue

Complete the exemption information for Charles, then add the information for Shay and both children:

Health Insurance/Exemption

Name of Individual: CHARLES BALDWIN

Do you have a marketplace-issued certificate for this exemption?: Yes

Exemption Certificate Number: A23BC45

Indicate full year or specify months for which you qualify to take the exemption.

Full Year

January February March

April May June

July August September

October November December

Cancel **Continue**

Health Coverage Exemptions

Name of Individual	Type	Edit	Delete
CHARLES BALDWIN	Certificate A23BC45	Edit	Delete

Add Add another exemption

Back **Continue**

Health Coverage Exemptions

Name of Individual	Type	Edit	Delete
NATHANIEL BALDWIN	Certificate A45BC67	Edit	Delete
KARLY BALDWIN	Certificate A56BC78	Edit	Delete
SHAY BALDWIN	Certificate A34BC56	Edit	Delete
CHARLES BALDWIN	Certificate A23BC45	Edit	Delete

Add Add another exemption

Back **Continue**

Results – Exemptions, Form 8965

Each member of the family received a coverage exemption from the Marketplace for the months of January, February, and March. See Part I of the Baldwin's completed Form 8965:

Form 8965 Department of the Treasury Internal Revenue Service		Health Coverage Exemptions Attach to Form 1040, Form 1040A, or Form 1040EZ. Information about Form 8965 and its separate instructions is at www.irs.gov/form8965 .		OMB No. 1545-0074 2016 Attachment Sequence No. 75
Name as shown on return		Your social security number		
CHARLES BALDWIN		609-00-1632		
Complete this form if you have a Marketplace-granted coverage exemption or you are claiming a coverage exemption on your return.				
Part I Marketplace-Granted Coverage Exemptions for Individuals. If you and/or a member of your tax household have an exemption granted by the Marketplace, complete Part I.				
	(a) Name of Individual	(b) SSN	(c) Exemption Certificate Number	
1	CHARLES BALDWIN	609-00-1632	A23BC45	
2	SHAY BALDWIN	610-00-1632	A34BC56	
3	NATHANIEL BALDWIN	611-00-1632	A45BC67	
4	KARLY BALDWIN	612-00-1632	A56BC78	
5				

Results – Premium Tax Credit, Form 8962

See Parts 1, 2, and 3 of Charles and Shay's completed Form 8962 below. Part 3 of Form 8962 reconciles advance payments of the premium tax credit.

In this case, Charles failed to report an increase in pay to the Marketplace. This resulted in an excess advance premium tax credit repayment. This excess will decrease their refund or increase their balance due. Charles should have reported his change in income to the Marketplace so they could have adjusted his advance credit payments for the remainder of the coverage year.

Premium Tax Credit (PTC)

Department of the Treasury
Internal Revenue Service

▶ Attach to Form 1040, 1040A, or 1040NR.
▶ Information about Form 8962 and its separate instructions is at www.irs.gov/form8962.

Name shown on your return

Your social security number

CHARLES BALDWIN

609-00-XXXX

You cannot claim the PTC if your filing status is married filing separately unless you qualify for an exception (see instructions). If you qualify, check the box.

Part I Annual and Monthly Contribution Amount

1	Tax family size. Enter the number of exemptions from Form 1040 or Form 1040A, line 6d, or Form 1040NR, line 7d	1	4
2a	Modified AGI. Enter your modified AGI (see instructions)	2a	51,250
	b Enter the total of your dependents' modified AGI (see instructions)	2b	
3	Household income. Add the amounts on lines 2a and 2b	3	51,250
4	Federal poverty line. Enter the federal poverty line amount from Table 1-1, 1-2, or 1-3 (see instructions). Check the appropriate box for the federal poverty table used. a <input type="checkbox"/> Alaska b <input type="checkbox"/> Hawaii c <input checked="" type="checkbox"/> Other 48 states and DC	4	24,250
5	Household income as a percentage of federal poverty line (see instructions)	5	211 %
6	Did you enter 401% on line 5? (See instructions if you entered less than 100%.) <input checked="" type="checkbox"/> No. Continue to line 7. <input type="checkbox"/> Yes. You are not eligible to take the PTC. If advance payment of the PTC was made, see the instructions for how to report your excess advance PTC repayment amount.		
7	Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions	7	0.0680
8a	Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount	8a	3,485
	b Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount	8b	290

Part II Premium Tax Credit Claim and Reconciliation of Advance Payment of Premium Tax Credit

- 9** Are you allocating policy amounts with another taxpayer or do you want to use the alternative calculation for year of marriage (see instructions)?
 Yes. Skip to Part IV, Allocation of Policy Amounts, or Part V, Alternative Calculation for Year of Marriage. **No.** Continue to line 10.
- 10** See the instructions to determine if you can use line 11 or must complete lines 12 through 23.
 Yes. Continue to line 11. Compute your annual PTC. Then skip lines 12–23 and continue to line 24.
 No. Continue to lines 12–23. Compute your monthly PTC and continue to line 24.

Annual Calculation	(a) Annual enrollment premiums (Form(s) 1095-A, line 33A)	(b) Annual applicable SLCSP premium (Form(s) 1095-A, line 33B)	(c) Annual contribution amount (line 8a)	(d) Annual maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Annual premium tax credit allowed (smaller of (a) or (d))	(f) Annual advance payment of PTC (Form (s) 1095-A, line 33C)	
11 Annual Totals							
Monthly Calculation	(a) Monthly enrollment premiums (Form(s) 1095-A, lines 21–32, column A)	(b) Monthly applicable SLCSP premium (Form (s) 1095-A, lines 21–32, column B)	(c) Monthly contribution amount (amount from line 8b or alternative marriage monthly calculation)	(d) Monthly maximum premium assistance (subtract (c) from (b), if zero or less, enter -0-)	(e) Monthly premium tax credit allowed (smaller of (a) or (d))	(f) Monthly advance payment of PTC (Form(s) 1095-A, lines 21–32, column C)	
12 January							
13 February							
14 March							
15 April	789	789	290	499	499	607	
16 May	789	789	290	499	499	607	
17 June	789	789	290	499	499	607	
18 July	789	789	290	499	499	607	
19 August	789	789	290	499	499	607	
20 September	789	789	290	499	499	607	
21 October	789	789	290	499	499	607	
22 November	789	789	290	499	499	607	
23 December	789	789	290	499	499	607	
24	Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here					24	4,491
25	Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here					25	5,463
26	Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Form 1040, line 69; Form 1040A, line 45; or Form 1040NR, line 65. If line 24 equals line 25, enter zero. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27					26	

Part III Repayment of Excess Advance Payment of the Premium Tax Credit

27	Excess advance payment of PTC. If line 25 is greater than line 24, subtract line 24 from line 25. Enter the difference here	27	972
28	Repayment limitation (see instructions)	28	1,500
29	Excess advance premium tax credit repayment. Enter the smaller of line 27 or line 28 here and on Form 1040, line 46; Form 1040A, line 29; or Form 1040NR, line 44	29	972

For Paperwork Reduction Act Notice, see your tax return instructions.

Cat. No. 37784Z

Form **8962** (2016)

Results – Form 1040, page 2

45 Alternative minimum tax. Attach Form 6251	0
46 Excess advance premium tax credit repayment. Form 8962	972

The “Full-year coverage” box is not checked.

61 Health care: individual responsibility	Full-year coverage: <input type="checkbox"/>	0
--	--	---

Link & Learn Taxes

Link & Learn Taxes is web-based training designed specifically for VITA/TCE volunteers. Each volunteer's ability to prepare complete and accurate returns is vital to the credibility and integrity of the program. Link & Learn Taxes, as part of the complete volunteer training kit, provides the path to achieving this high level of quality service.

Link & Learn Taxes and the printed technical training kit, Publication 4480, work together to help volunteers learn and practice.

Link & Learn Taxes for 2016 includes:

- Access to all VITA/TCE courses
- Easy identification of the VITA/TCE courses with the course icons
 - As you progress through a lesson, the content for Basic, Advanced, Military, or International will display, depending on the level of certification you selected
- PowerPoint presentations that can be customized to fit your classroom needs
- VITA/TCE Central to provide centralized access for training materials and reference links
- The Practice Lab
 - Gives volunteers practice with an early version of the IRS-provided tax preparation software
 - Lets volunteers complete workbook problems from Publication 4491W
 - Lets volunteers prepare test scenario returns for the test/retest



Go to www.irs.gov, type “Link & Learn” in the Keyword field and click Search. You’ll find a detailed overview and links to the courses.

FSA (Facilitated Self Assistance) empowers taxpayers to prepare their own return with the assistance of a certified volunteer. Taxpayers complete their own return using interview-based software supplied by leaders in the tax preparation industry. Volunteers assist taxpayers with tax law and software questions.

Virtual VITA allows partners to initiate the intake process for taxpayers in one location, while utilizing a certified volunteer to prepare the return in an entirely different location. By incorporating this flexibility, partners can provide taxpayers with more convenient locations to file their taxes.

For more information contact your SPEC Relationship Manager to see if you should start a FSA or Virtual VITA site in your community.



Your online resource for volunteer and taxpayer assistance

Partner and Volunteer Resource Center

<https://www.irs.gov/Individuals/Partner-and-Volunteer-Resource-Center>

- What's Hot!
- Site Coordinator's Corner

Quality and Tax Alerts for IRS Volunteer Programs

<https://www.irs.gov/Individuals/Quality-and-Tax--Alerts-for-IRS-Volunteer-Programs>

- Volunteer Tax Alerts

Volunteer Training Resources

<https://www.irs.gov/Individuals/Volunteer-Training-Resources>

Outreach Corner

<https://www.irs.gov/Individuals/Outreach-Corner>

Tax Trails for Answers to Common Tax Questions

<https://www.irs.gov/Individuals/Tax-Trails---Main-Menu>

Online Services and Tax Information for Individuals

<https://www.irs.gov/Individuals>

File Your Return

- Direct Deposit your refund

Make a Payment

- Direct Pay
- Other ways you can pay
(Electronic funds withdrawal, debit and credit card, and IRS2Go)
- [myRA](#)

Manage Your Tax Info

- Withholding Calculator
- Answers about the Health Care Law
- Protect your identity

After You File

- Where's My Refund?
- Get Transcript

eBooks

Want to view our training products on your mobile or tablet devices? Click here to access our eBooks: <https://www.irs.gov/Individuals/Site-Coordinator-Corner>.

Mobile App

Another device to use for additional information is IRS2Go. Click here to download IRS2Go mobile app: <https://www.irs.gov/uac/irs2goapp>.

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