



DATE: \_\_\_\_\_

**Do you have more than one year's return to file? YES NO**

**Were you covered under the Healthcare Marketplace? YES NO**

\*MAILING ADDRESS: \_\_\_\_\_

\*CITY: \_\_\_\_\_ \*STATE: \_\_\_\_\_ \*ZIP CODE: \_\_\_\_\_

**\*\*If you are filing with a spouse, please write your names in the same order as they were on last year's return\*\***

\*PRIMARY TAXPAYER NAME: \_\_\_\_\_

\*S.S.N.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \*D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Occupation: \_\_\_\_\_

\*Daytime Phone: \_\_\_\_\_ \*Cell Phone: \_\_\_\_\_

\*E-MAIL: \_\_\_\_\_

\*SPOUSE'S NAME: \_\_\_\_\_

\*S.S.N.: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ \*D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ \*Occupation: \_\_\_\_\_

\*Daytime Phone: \_\_\_\_\_ \*Cell Phone: \_\_\_\_\_

\*E-MAIL: \_\_\_\_\_

**Dependent #1**

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*S.S.N.: \_\_\_\_\_ \*D.O.B. \_\_\_\_\_ \*Relationship: \_\_\_\_\_

**Daycare Expenses? \_\_\_\_ YES \_\_\_\_ NO If over 19, in college? \_\_\_\_ YES \_\_\_\_ NO**

**Dependent #2**

\*First Name: \_\_\_\_\_ \*Last Name: \_\_\_\_\_

\*S.S.N.: \_\_\_\_\_ \*D.O.B. \_\_\_\_\_ \*Relationship: \_\_\_\_\_

**Daycare Expenses? \_\_\_\_ YES \_\_\_\_ NO If over 19, in college? \_\_\_\_ YES \_\_\_\_ NO**

\*\*\*\*\*

**Direct Deposit Bank Information**

**(optional; can be provided later when needed)**

**Name of Bank: \_\_\_\_\_ Checking \_\_\_\_ Savings \_\_\_\_**

**Account Number: \_\_\_\_\_**

**Routing Number: \_\_\_\_\_ (ONLY needed for out-of-town banks)**