



# 5157A

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

**2018 RETURNS**



Take your VITA/TCE training online at [www.irs.gov](http://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 from customers.
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

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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.

### 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

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#### 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 the Practice Lab. 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.

Greg's intake sheet, page 1:

Form-13614-C (October 2018)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>				OMB Number 1545-1964	
<b>You will need:</b> <ul style="list-style-type: none"> <li>• Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>• Social security cards or ITIN letters for all persons on your tax return.</li> <li>• Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>				<ul style="list-style-type: none"> <li>• Please complete pages 1-3 of this form.</li> <li>• You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>• If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>			
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>							
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)							
1. Your first name <b>GREG</b>		M.I.	Last name <b>CLAYTON</b>		Daytime telephone number <b>YOUR PHONE #</b>		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		Daytime telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Mailing address <b>55 CONCORD COURT</b>				Apt #	City <b>YOUR CITY</b>		State <b>YS</b> ZIP code <b>YOUR ZIP</b>
4. Your Date of Birth <b>7/22/1987</b>		5. Your job title <b>SALES REP</b>		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 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 as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure							
11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
<b>Part II – Marital Status and Household Information</b>							
1. As of December 31, 2018, what was your marital status? <input checked="" type="checkbox"/> Never Married (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input type="checkbox"/> Married							
a. If Yes, Did you get married in 2018? <input type="checkbox"/> Yes <input type="checkbox"/> No							

Greg's intake sheet, page 3:

Check appropriate box for each question in each section				Page 3													
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>														
<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?														
Completed by: [Redacted] Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)																	

Greg's Form 1095-B from Employer A:

<b>Part IV Covered Individuals</b> (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 [Redacted]	[Redacted]	[Redacted]	<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"/>

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 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"/>	<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. Determine that he is eligible for a short coverage gap exemption, and enter this on the 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		
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		

**Results – TaxSlayer ACA Responses**

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

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2017?

Yes

No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

Yes

No

# Verify Your Household Members



If you have additional family members that are neither a spouse nor a dependent, click "[Add a New Household Member](#)."

If you need to add or remove dependents, [click here to go to Personal Information](#).

+ Add New Household Member

Name	SSN	Date of Birth
Greg Clayton	621-00-XXXX	7/22/1987

+ Add New Household Member

## Months Insured

Was your entire household insured for all 12 months of 2017? \*

- Yes  
 No

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

Name	Months Insured
Greg Clayton	10

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.

## Months Insured - Greg Clayton

Be sure to include the month of June. Individuals are treated as having MEC for the month if they had coverage for at least one day of the month.

Specify the 10 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  |

Leave this screen blank for Greg.

## Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income. (Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

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

## Health Care Exemptions



You do not qualify for the exemption based on Household or Gross Income below Filing Threshold, but if you or another household member received a Marketplace Issued Exemption Certificate or qualify for a coverage exemption, please refer to the question below.

**Did you qualify for an exemption due to circumstances or receive an exemption certificate from the marketplace?**

- Yes
- No

Check the box for each month that the exemption applies.

### Health Care Exemption

Name of Individual \*

Greg Clayton ▾

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

Yes

No

Exemption Type on the return

Short gap in coverage ▾

Indicate full year or specify months for which you qualify to take the exemption. (Note: Selecting "Coverage is Unaffordable" above will prompt the Affordability Worksheet when continuing)

Full Year

<input type="checkbox"/> January	<input type="checkbox"/> February	<input type="checkbox"/> March	<input checked="" type="checkbox"/> April
<input checked="" 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

### Health Coverage Exemptions

⊕ Add another exemption

Name of Individual	Type	
Greg Clayton	B	 

⊕ Add another exemption

### Results – Form 1040

Greg will not be required to pay any shared responsibility payment. Greg’s Form 1040 will have the “Full-year health care coverage or exempt” box marked and he will not make an individual shared responsibility payment.

<input checked="" type="checkbox"/> Full-year health care coverage or exempt (see inst.)
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## Example 2 – Coverage Exemptions, Code G – Resident of a state that did not expand Medicaid

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### 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 2018.
- 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 the Practice Lab. 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 2018)	Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>	OMB Number 1545-1964											
<p><b>You will need:</b></p> <ul style="list-style-type: none"> <li>• Tax information such as Forms W-2, 1099, 1098, 1095.</li> <li>• Social security cards or ITIN letters for all persons on your tax return.</li> <li>• Picture ID (such as valid driver's license) for you and your spouse.</li> </ul> <p style="text-align: center;"><b>Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a></b></p>													
<p><b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)</p>													
1. Your first name <b>JEROME</b>	M.I.	Last name <b>BAXTER</b>	Daytime telephone number <b>YOUR PHONE #</b>	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
2. Your spouse's first name <b>JUDY</b>	M.I.	Last name <b>BAXTER</b>	Daytime telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
3. Mailing address <b>33 APACHE WAY</b>			Apt #	City <b>YOUR CITY</b>									
4. Your Date of Birth <b>07/09/1979</b>	5. Your job title <b>SALES</b>		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 <b>12/01/1983</b>	8. Your spouse's job title <b>HOMEMAKER</b>		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 as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2018, what was your marital status?													
<input type="checkbox"/> Never Married (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 2018? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
b. Did you live with your spouse during any part of the last six months of 2018? <input checked="" type="checkbox"/> Yes <input 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													
<b>To be completed by a Certified Volunteer Preparer</b>													
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 12/31/18 (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 \$4,150 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)
<b>JANA BAXTER</b>	<b>02/04/2015</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

Page 3			
<b>Check appropriate box for each question in each section</b>			
<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>
<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, 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?
<small>To be Completed by Certified Volunteer Preparer (Use Publication 4012 and check the appropriate box(es) indicating Minimum Essential Coverage (MEC) for everyone listed on the return.)</small>			

### Results – Approaching the ACA

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, Other Taxes, Payments, and ACA tab, to find the income amount for a family of three at 138% FPL (\$28,180). 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's intake sheet, Part VI:

3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?  
   4. (B) Have an exemption granted by the Marketplace?

**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	MEC All Year	No MEC	Months with MEC	Months with Exemption	Exempt 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		Coverage 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		

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

1. Provide an email address (optional) (this email address will not be used for contacts from the Internal Revenue Service) \_\_\_\_\_

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

Check here if you, or your spouse if filing jointly, want \$3 to go to this fund  You  Spouse

## 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 2017?

Yes  
 No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

Yes  
 No

### Verify Your Household Members

**i** If you have additional family members that are neither a spouse nor a dependent, click "[Add a New Household Member](#)."

If you need to add or remove dependents, [click here to go to Personal Information](#).

**+** Add New Household Member

Name	SSN	Date of Birth
JEROME BAXTER	623-00-XXXX	7/9/1979
JUDY BAXTER	624-00-XXXX	12/1/1983
JANA BAXTER	625-00-XXXX	2/4/2015

## Months Insured

Was your entire household insured for all 12 months of 2017? \*

Yes

No

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

Name	Months Insured
JEROME BAXTER	0
JUDY BAXTER	0
JANA BAXTER	12

There was no salary reduction arrangement and Jana did not have a filing requirement. Leave this screen blank.

## Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income.

(Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

\$

## 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

\$

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

\$

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.

## Health Care Exemptions



You do not qualify for the exemption based on Household or Gross Income below Filing Threshold, but if you or another household member received a Marketplace Issued Exemption Certificate or qualify for a coverage exemption, please refer to the question below.

Did you qualify for an exemption due to circumstances or receive an exemption certificate from the marketplace?

Yes

No

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. Make the same entries for Judy.

## Health Care Exemption

Name of Individual \*

Jerome Baxter ▾

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

Yes

No

Exemption Type on the return

Resident of a state that did not expand Medicaid ▾

Indicate full year or specify months for which you qualify to take the exemption. (Note: Selecting "Coverage is Unaffordable" above will prompt the Affordability Worksheet when continuing)

Full Year

## Health Coverage Exemptions

+ Add another exemption

Name of Individual	Type	
Jerome Baxter	G	
+ Add another exemption ←	<b>Select Add another exemption</b>	

## Health Care Exemption

Name of Individual \*

Judy Baxter ▾

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

Yes

No

Exemption Type on the return

Resident of a state that did not expand Medicaid ▾

Indicate full year or specify months for which you qualify to take the exemption. (Note: Selecting "Coverage is Unaffordable" above will prompt the Affordability Worksheet when continuing)

Full Year

## Health Coverage Exemptions

⊕ Add another exemption

Name of Individual	Type	
Judy Baxter	G	 
Jerome Baxter	G	 

⊕ Add another exemption

## Results – Form 1040

Jerome and Judy qualify for a full-year coverage exemption and Jana had health care coverage all year. They can check the box on the front of Form 1040 and are not required to file Form 8965. No individual shared responsibility payment is required.

Full-year health care coverage  
or exempt (see inst.)

## Example 3 – Coverage Exemptions, Code A – Employer coverage considered unaffordable

---

### 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 the Practice Lab. 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 2018)	Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>		OMB Number 1545-1964										
<b>You will need:</b> <ul style="list-style-type: none"> <li>Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>Social security cards or ITIN letters for all persons on your tax return.</li> <li>Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>		<ul style="list-style-type: none"> <li>Please complete pages 1-3 of this form.</li> <li>You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>											
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>													
<b>Part I - Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>LEE</b>	M.I.	Last name <b>PARKS</b>	Daytime telephone number <b>YOUR PHONE #</b>										
2. Your spouse's first name <b>SUSAN</b>	M.I.	Last name <b>PARKS</b>	Daytime telephone number										
3. Mailing address <b>87 HASTINGS BLVD</b>		Apt #	City <b>YOUR CITY</b>										
4. Your Date of Birth <b>06/01/1968</b>	5. Your job title <b>CONSTRUCTION</b>	6. Last year, were you:											
7. Your spouse's Date of Birth <b>04/05/1970</b>	8. Your spouse's job title <b>SALES</b>	9. Last year, was your spouse:											
10. Can anyone claim you or your spouse as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure		11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
<b>Part II - Marital Status and Household Information</b>													
1. As of December 31, 2018, what was your marital status? <input type="checkbox"/> Never Married (This includes registered domestic partnerships, civil unions, or other formal relationships under state law) <input checked="" type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed													
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													
										<b>To be completed by a Certified Volunteer Preparer</b>			
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 12/31/18 (SM)	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 \$4,150 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

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? <b>SUSAN</b>											
<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?											

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	Sep	Oct	Nov	Dec	
29 SUSAN PARKS	614-00-XXXX	04/05/1970	<input checked="" type="checkbox"/>	<input type="checkbox"/>												

Form 1095-C for Susan Parks:

<b>Form 1095-C</b> Department of the Treasury Internal Revenue Service		<b>Employer-Provided Health Insurance Offer and Coverage</b> Do not attach to your tax return. Keep for your records. Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.				OMB No. 1545-2251 <b>2018</b>													
<b>Part I Employee</b>				<b>Applicable Large Employer Member (Employer)</b>															
1 Name of employee (first name, middle initial, last name) <b>SUSAN PARKS</b>		2 Social security number (SSN) <b>614-00-XXXX</b>		7 Name of employer <b>EMPLOYER A</b>		8 Employer identification number (EIN) <b>62-200XXXX</b>													
3 Street address (including apartment no.) <b>87 HASTINGS BLVD</b>				9 Street address (including room or suite no.) <b>1 FIRST AVENUE</b>															
4 City or town <b>YOUR CITY</b>		5 State or province <b>YS</b>		6 Country and ZIP or foreign postal code <b>YOUR ZIP</b>		10 Contact telephone number <b>YOUR PHONE</b>													
11 City or town <b>YOUR CITY</b>		12 State or province <b>YS</b>		13 Country and ZIP or foreign postal code <b>YOUR ZIP</b>															
<b>Part II Employee Offer of Coverage</b>				<b>Plan Start Month</b> (enter 2-digit number):															
14 Offer of Coverage (enter required code) <b>1E</b>		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec						
15 Employee Required Contribution (see instructions) \$ <b>260</b>		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$						
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) <b>2C</b>																			
<b>Part III Covered Individuals</b> If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. <input type="checkbox"/>																			
(a) Name of covered individual(s) First name, middle initial, last name		(b) SSN or other TIN		(c) DOB (if SSN or other TIN is not available)		(d) Covered all 12 months		(e) Months of Coverage											
17 <b>SUSAN PARKS</b>		<b>614-00-XXXX</b>		<b>04/05/1970</b>		<input checked="" type="checkbox"/>		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
								<input type="checkbox"/>											

### Results – Approaching the ACA

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

## Results – TaxSlayer ACA Responses

Answer the ACA questions for Susan and Lee as shown below.

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2017?

- Yes  
 No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

- Yes  
 No

## Verify Your Household Members



If you have additional family members that are neither a spouse nor a dependent, click "[Add a New Household Member](#)."

If you need to add or remove dependents, [click here to go to Personal Information](#).

+ Add New Household Member

Name	SSN	Date of Birth
Lee Parks	613-00-XXXX	6/1/1968
Susan Parks	614-00-XXXX	4/5/1970
Elisabeth Parks	615-00-XXXX	3/2/2012
Emilee Parks	616-00-XXXX	9/7/2007

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 2017? \*

Yes

No

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

Name	Months Insured
Lee Parks	0
Susan Parks	12
Elisabeth Parks	0
Emilee Parks	0

The children do not have a filing requirement. Leave this screen blank.

### Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income. (Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

\$|

#### 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

\$

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

\$

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



You do not qualify for the exemption based on Household or Gross Income below Filing Threshold, but if you or another household member received a Marketplace Issued Exemption Certificate or qualify for a coverage exemption, please refer to the question below.

Did you qualify for an exemption due to circumstances or receive an exemption certificate from the marketplace?

- Yes
- No

Would you like to determine if you qualify for an exemption due to unaffordable premiums?

- Yes
- No

Follow the steps in Publication 4012, tab H, Coverage is Unaffordable page. Leave this screen blank for these taxpayers.

## Do you qualify for Health Care Exemptions?



You only need to fill in these values if a household member was not eligible for employer-sponsored coverage for one or more months. These values will be used to compute your annualized required contribution from the Marketplace Coverage Affordability Worksheet.

To determine if you can claim the "Coverage is Considered Unaffordable" exemption if health insurance was not offered through an employer, enter the premium values captured from the healthcare.gov tax tool that is made available to you. The link at the bottom of this page will assist you in determining the needed premium amounts. Note: If you were eligible for employer-sponsored coverage, select continue below and enter the required information asked to further determine affordability.

Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)

\$

Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)

\$

[Click here to obtain the LCBP and SLCSPP premium amounts to enter above.](#)

[Click here to determine if you can claim a health coverage exemption.](#)

Enter the annualized premium for Susan's share of the cost for family coverage for each month for Lee, Elisabeth, and Emilee (\$13,140).

**Enter the ANNUALIZED contribution amount this individual must pay for the first situation below that applies to the individual.**

Enter the required ANNUALIZED contribution for **each month** that applies to this individual:

1. Lowest cost self-only policy offered to each member of your tax household by his/her employer (the monthly amount times 12).
2. Lowest cost family policy offered by your employer or your spouse's employer (the monthly amount times 12).
3. Amount from the Marketplace Coverage Affordability Worksheet. (\$0)

**LEE PARKS**

January

\$ 13140

February

\$ 13140

Lee and Susan's share of the cost for family coverage (\$13,140) is more than 8.05% of their household income ( $\$57,000 \times .0805 = \$4,589$ ). As a result, Lee, Elisabeth, and Emilee are eligible for the exemption for unaffordable coverage for the tax year.

## Coverage Considered Unaffordable Exemption



Based on the information calculated using the Affordability Worksheet, you qualify to claim the Coverage is Considered Unaffordable exemption. This exemption has been automatically applied to the appropriate months for the applicable household members on the return.

BACK

CONTINUE

## Results – Form 1040

Lee, Elisabeth, and Emilee qualify for full-year coverage exemptions and Susan had health care coverage all year. They can check the box on the front of Form 1040 and are not required to file Form 8965. No individual shared responsibility payment is required.

<input checked="" type="checkbox"/> Full-year health care coverage or exempt (see inst.)
--

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

<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?

**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	MEC All Year	No MEC	Months with MEC	Months with Exemption	Exempt All Year	Notes
Taxpayer <b>LEE</b>		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 <b>SUSAN</b>	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 <b>ELISABETH</b>		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 <b>EMILEE</b>		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		

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

## Example 4 – Coverage Exemptions – Code A Marketplace Coverage Considered Unaffordable

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### Interview Notes

- Edward and Julia Fulton are married and file a joint return. The Fultons have a dependent son, Sam. Their SSNs are:
  - Edward: 617-00-XXXX
  - Julia: 618-00-XXXX
  - Sam: 619-00-XXXX
- Julia and Edward were not offered insurance coverage through their employers and were not eligible or enrolled for any other minimum essential coverage for any month during the tax year.
- 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.
- The Fultons 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 the Practice Lab. Enter the SSN, filing status, dependents, personal information, and income. Then complete the following steps:

1. Select the Health Insurance section and answer all the questions pertaining to Edward, Julia, and Sam.
2. Determine if this couple is eligible for the affordability exemption.
3. Compare your result to the screen shots on the following pages.

Form-13614-C (October 2018)	Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>		OMB Number 1545-1964										
<b>You will need:</b> <ul style="list-style-type: none"> <li>Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>Social security cards or ITIN letters for all persons on your tax return.</li> <li>Picture ID (such as valid driver's license) for you and your spouse.</li> </ul>			<ul style="list-style-type: none"> <li>Please complete pages 1-3 of this form.</li> <li>You are responsible for the information on your return. Please provide complete and accurate information.</li> <li>If you have questions, please ask the IRS-certified volunteer preparer.</li> </ul>										
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>													
<b>Part I - Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>EDWARD</b>	M.I.	Last name <b>FULTON</b>	Daytime telephone number <b>YOUR PHONE #</b>	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
2. Your spouse's first name <b>JULIA</b>	M.I.	Last name <b>FULTON</b>	Daytime telephone number	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
3. Mailing address <b>456 STONEHILL RD</b>		Apt #	City <b>YOUR CITY</b>	State <b>YS</b> ZIP code <b>YOUR ZIP</b>									
4. Your Date of Birth <b>06/01/1978</b>	5. Your job title <b>MANAGER</b>	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 <b>01/06/1979</b>	8. Your spouse's job title <b>CUSTOMER SERVICE REP</b>	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 as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
<b>Part II - Marital Status and Household Information</b>													
1. As of December 31, 2018, what was your marital status?													
<input type="checkbox"/> Never Married		(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 2018? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
<input type="checkbox"/> Divorced		b. Did you live with your spouse during any part of the last six months of 2018? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No											
<input type="checkbox"/> Legally Separated		Date of final decree _____											
<input type="checkbox"/> Widowed		Date of separate maintenance agreement _____											
		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													
<b>To be completed by a Certified Volunteer Preparer</b>													
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 12/31/18 (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 \$4,150 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>SAM FULTON</b>	(b) <b>05/19/2012</b>	(c) <b>SON</b>	(d) <b>12</b>	(e) <b>YES</b>	(f) <b>YES</b>	(g) <b>S</b>	(h) <b>YES</b>	(i) <b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

Page 3			
<b>Check appropriate box for each question in each section</b>			
<b>Yes</b>	<b>No</b>	<b>Unsure</b>	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>
<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 - Approaching the ACA**

## Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2017?

Yes

No

# Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

Yes

No

## Verify Your Household Members



If you have additional family members that are neither a spouse nor a dependent, click "[Add a New Household Member](#)."

If you need to add or remove dependents, [click here to go to Personal Information](#).

Add New Household Member

Name	SSN	Date of Birth
EDWARD FULTON	617-00-XXXX	6/1/1978
JULIA FULTON	618-00-XXXX	1/6/1979
SAM FULTON	619-00-XXXX	5/19/2012

## Months Insured

Was your entire household insured for all 12 months of 2017? \*

Yes

No

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"/> ▼

## Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income. (Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

\$|

## 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

\$

## Health Care Exemptions



You do not qualify for the exemption based on Household or Gross Income below Filing Threshold, but if you or another household member received a Marketplace Issued Exemption Certificate or qualify for a coverage exemption, please refer to the question below.

**Did you qualify for an exemption due to circumstances or receive an exemption certificate from the marketplace?**

- Yes
- No

**Would you like to determine if you qualify for an exemption due to unaffordable premiums?**

- Yes
- No

## Results – Affordability Worksheet

TaxSlayer determines the Affordability Threshold based on the household income.

The calculation is:  $\$40,180 \times .0805$  (affordability threshold is 8.05% of household income for 2018) = \$3,234.

Since Edward and Julia live in a state that does not have its own Marketplace, visit [www.healthcare.gov/tax-tool](http://www.healthcare.gov/tax-tool) to find the figures you will need to determine exemption eligibility.

- 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 where indicated in TaxSlayer.
- Then look up the second lowest cost silver plan (SLCSP) for Edward and Julia. Do not include Sam in this quote because he has government-sponsored coverage. Enter this figure in TaxSlayer. For this example, we used the following figures based on tax year 2017: LCBP: \$553, SLCSP: \$496.
- TaxSlayer will determine eligibility for the exemption.

### Do you qualify for Health Care Exemptions?



You only need to fill in these values if a household member was not eligible for employer-sponsored coverage for one or more months. These values will be used to compute your annualized required contribution from the Marketplace Coverage Affordability Worksheet.

To determine if you can claim the "Coverage is Considered Unaffordable" exemption if health insurance was not offered through an employer, enter the premium values captured from the [healthcare.gov](http://healthcare.gov) tax tool that is made available to you. The link at the bottom of this page will assist you in determining the needed premium amounts. Note: If you were eligible for employer-sponsored coverage, select continue below and enter the required information asked to further determine affordability.

Monthly Premium for the Lowest Cost Bronze Plan Premium (worksheet line 1)

\$ 553 x

Monthly Premium for the Second Lowest Cost Silver Plan Premium (worksheet line 10)

\$ 496

[Click here to obtain the LCBP and SLCSP premium amounts to enter above.](#)

[Click here to determine if you can claim a health coverage exemption.](#)

Enter the ANNUALIZED contribution amount for Edward and next do the same for Julia.

## Affordability Worksheet - EDWARD FULTON

BACK

CONTINUE

Enter the ANNUALIZED contribution amount this individual must pay for the first situation below that applies to the individual.

Enter the required ANNUALIZED contribution for each month that applies to this individual:

1. Lowest cost self-only policy offered to each member of your tax household by his/her employer (the monthly amount times 12).
2. Lowest cost family policy offered by your employer or your spouse's employer (the monthly amount times 12).
3. Amount from the Marketplace Coverage Affordability Worksheet. (\$2280)

### EDWARD FULTON

January

\$ 2280

February

\$ 2280

March

\$ 2280

April

\$ 2280

May

\$ 2280

June

\$ 2280

July

\$ 2280

August

\$ 2280

September

\$ 2280

October

\$ 2280

November

\$ 2280

December

\$ 2280

Based on your entries, Edward and Julia can't claim the affordability exemption.

## Coverage Considered Unaffordable Exemption



Based on the information calculated using the Affordability Worksheet, you do not qualify to claim the Coverage is Considered Unaffordable exemption.

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

<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?

**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	MEC All Year	No MEC	Months with MEC	Months with Exemption	Exempt All Year	Notes
Taxpayer <b>EDWARD</b>		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		<b>No exemption</b>
Spouse <b>JULIA</b>		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		<b>No exemption</b>
Dependent <b>SAM</b>	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		<b>covered by CHP</b>
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		

Since Edward and Julia didn't have health insurance coverage for any month of the year and weren't eligible for an exemption, their shared responsibility payment will carry over to Form 1040, Schedule 4.

### Results – Form 1040, Schedule 4

The shared responsibility payment will carry over to Edward and Julia's tax return as shown below:

	required	<b>60b</b>		
<b>61</b>	Health care: individual responsibility (see instructions)	<b>61</b>	<b>1390</b>	<b>00</b>
<b>62</b>	Taxes from: a <input type="checkbox"/> Form 8959 b <input type="checkbox"/> Form 8960			



## Example 5 – Premium Tax Credit with APTC

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### 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.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using the Practice Lab. 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.

Sheryl's intake sheet, page 1, with the volunteer section completed:

Form-13614-C (October 2018)		Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>						OMB Number 1545-1964					
<b>You will need:</b> • 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.				<b>Please complete pages 1-3 of this form.</b> • 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.									
Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a>													
<b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)													
1. Your first name <b>SHERYL</b>		M.I.	Last name <b>GRAVES</b>		Daytime telephone number <b>YOUR PHONE #</b>		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		Daytime telephone number		Is your spouse a U.S. citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No						
3. Mailing address <b>321 MARTIN ROAD</b>				Apt #	City <b>YOUR CITY</b>		State <b>YS</b>	ZIP code <b>YOUR ZIP</b>					
4. Your Date of Birth <b>06/17/1979</b>		5. Your job title <b>CLERK</b>		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 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 as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2018, what was your marital status? <input type="checkbox"/> Never Married (This includes registered domestic partnerships, civil unions, or other formal relationships under state law)													
<input type="checkbox"/> Married a. If Yes, Did you get married in 2018? <input type="checkbox"/> Yes <input type="checkbox"/> No													
<input checked="" type="checkbox"/> Divorced b. Did you live with your spouse during any part of the last six months of 2018? <input type="checkbox"/> Yes <input type="checkbox"/> No													
Date of final decree <b>4/27/2010</b>													
<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													
<b>To be completed by a Certified Volunteer Preparer</b>													
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 12/31/18 (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 \$4,150 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	03/01/2001	DAUGHTER	12	YES	YES	S	YES	NO	NO	NO	YES	YES	YES
TRAVIS GRAVES	12/25/2002	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

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 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?												

Monique Floyd's Form 1095-B:

<b>Part IV Covered Individuals</b> (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 Monique Floyd	608-00-XXXX	05/05/1944	<input checked="" type="checkbox"/>	<input type="checkbox"/>											

**Part I Recipient Information**

1 Marketplace identifier <b>XXXXX</b>	2 Marketplace-assigned policy number <b>XXXXXX</b>	3 Policy issuer's name <b>XXXXXXXXXXXX</b>
4 Recipient's name <b>SHERYL GRAVES</b>	5 Recipient's SSN <b>605-00-XXXX</b>	6 Recipient's date of birth <b>06/17/1979</b>
7 Recipient's spouse's name	8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth
10 Policy start date <b>01/01/2018</b>	11 Policy termination date <b>12/31/2018</b>	12 Street address (including apartment no.) <b>321 MARTIN ROAD</b>
13 City or town <b>YOUR CITY</b>	14 State or province <b>YOUR STATE</b>	15 Country and ZIP or foreign postal code <b>YOUR ZIP</b>

**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	<b>SHERYL GRAVES</b>	<b>605-00-XXXX</b>	<b>06/17/1979</b>	<b>01/01/2018</b>	<b>12/31/2018</b>
17	<b>TRINA GRAVES</b>	<b>606-00-XXXX</b>	<b>03/01/2001</b>	<b>01/01/2018</b>	<b>12/31/2018</b>
18	<b>TRAVIS GRAVES</b>	<b>607-00-XXXX</b>	<b>12/25/2002</b>	<b>01/01/2018</b>	<b>12/31/2018</b>
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	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
22 February	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
23 March	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
24 April	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
25 May	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
26 June	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
27 July	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
28 August	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
29 September	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
30 October	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
31 November	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
32 December	<b>\$587.00</b>	<b>\$774.00</b>	<b>\$492.00</b>
33 Annual Totals	<b>\$7,044.00</b>	<b>\$9,288.00</b>	<b>\$5,904.00</b>

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

Cat. No. 60703Q

Form **1095-A** (2018)

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

3a. (A) If yes, were advance credit payments made to help you pay your health care premiums?  
   3b. (A) If yes, Is everyone listed on your Form 1095-A being claimed on this tax return?  
   4. (B) Have an exemption granted by the Marketplace?

**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	MEC All Year	No MEC	Months with MEC	Months with Exemption	Exempt All Year	Notes
Taxpayer <b>SHERYL</b>	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 <b>TRINA</b>	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 <b>TRAVIS</b>	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 <b>MONIQUE</b>	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

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

1. Provide an email address (optional) (this email address will not be used for contacts from the Internal Revenue Service) \_\_\_\_\_

## TaxSlayer ACA Responses

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 or your family have health insurance at any time in 2017?

Yes  
 No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

Yes  
 No

### Verify Your Household Members

**i** If you have additional family members that are neither a spouse nor a dependent, click "[Add a New Household Member](#)."

If you need to add or remove dependents, [click here to go to Personal Information](#).

**+** Add New Household Member

Name	SSN	Date of Birth
Sheryl Graves	605-00-XXXX	6/17/1979
Trina Graves	606-00-XXXX	3/1/2001
Travis Graves	607-00-XXXX	12/25/2002
Monique Floyd	608-00-XXXX	5/5/1944

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 2017? \*

- Yes
- No

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 2017? \*

Yes

No

Are you required to repay all of the APTC received? In most cases, the answer is NO. ONLY answer YES if you were not considered lawfully present in the U.S. or you meet the Health Coverage Tax Credit criteria. Note: We will automatically calculate a full repayment of APTC when MAGI is greater than 400 percent of Federal Poverty Line.

Yes

No

Is your household income below 100% of the Federal poverty line, and do you meet all of the requirements under either "Estimated household income at least 100% of the Federal poverty line" or "Alien lawfully present in the United States"?

Yes

No

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

Yes

No

### Please enter your annual Advance Premium Tax Credit information

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

\$ 7044

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

\$ 9288

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

\$ 5904 ×

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.

## Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income. (Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

\$|

## 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

\$

### Results – Form 1040

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

Full-year health care coverage  
or exempt (see inst.)

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**

**Premium Tax Credit (PTC)**

OMB No. 1545-0074

**2018**  
Attachment  
Sequence No. **73**

Department of the Treasury  
Internal Revenue Service

▶ Attach to Form 1040 or Form 1040NR.  
▶ Go to [www.irs.gov/Form8962](http://www.irs.gov/Form8962) for instructions and the latest information.

Name shown on your return  
**Sheryl Graves**

Your social security number  
**605-00-XXXX**

You cannot take 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**

<b>1</b>	Tax family size. Enter your tax family size (see instructions)	<b>1</b>	<b>4</b>
<b>2a</b>	Modified AGI. Enter your modified AGI (see instructions)	<b>2a</b>	<b>36429</b>
<b>b</b>	Enter the total of your dependents' modified AGI (see instructions)	<b>2b</b>	<b>0</b>
<b>3</b>	Household income. Add the amounts on lines 2a and 2b (see instructions)	<b>3</b>	<b>36429</b>
<b>4</b>	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. <b>a</b> <input type="checkbox"/> Alaska <b>b</b> <input type="checkbox"/> Hawaii <b>c</b> <input checked="" type="checkbox"/> Other 48 states and DC	<b>4</b>	<b>24,600</b>
<b>5</b>	Household income as a percentage of federal poverty line (see instructions)	<b>5</b>	<b>148 %</b>
<b>6</b>	Did you enter 401% on line 5? (See instructions if you entered less than 100%.) <input checked="" type="checkbox"/> <b>No.</b> Continue to line 7. <input type="checkbox"/> <b>Yes.</b> 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.		
<b>7</b>	Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions	<b>7</b>	<b>.0391</b>
<b>8a</b>	Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount	<b>8a</b>	<b>1424</b>
<b>b</b>	Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount	<b>8b</b>	<b>119</b>

**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)
<b>11 Annual Totals</b>	<b>7044</b>	<b>9288</b>	<b>1424</b>	<b>7864</b>	<b>7044</b>	<b>5904</b>
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)

<b>22</b>	November					
<b>23</b>	December					
<b>24</b>	Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here	<b>24</b>	<b>7044</b>			
<b>25</b>	Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here	<b>25</b>	<b>5904</b>			
<b>26</b>	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 -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27	<b>26</b>	<b>1140</b>			

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



Column C of Form 1095-A is entered on Form 8962, Column F.

Results – Form 1040, Schedule 5

<b>68–69</b>	Reserved	<b>68–69</b>	
<b>70</b>	Net premium tax credit. Attach Form 8962	<b>70</b>	<b>1140 00</b>
<b>71</b>	Amount paid with request for extension to file (see instructions)	<b>71</b>	

## Example 6 – Premium Tax Credit with APTC for Part-Year Coverage

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### 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. Charles enrolled in a plan through the Marketplace that covered him, Shay, and both children with an effective date of March 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 had health insurance coverage for all of 2017, and are eligible for the short coverage gap exemption for the months of January and February 2018.

### Directions

Review the interview notes, complete the volunteer sections of the intake sheet, and start a new return using the Practice Lab. 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.

Form-13614-C (October 2018)	Department of the Treasury - Internal Revenue Service <b>Intake/Interview &amp; Quality Review Sheet</b>	OMB Number 1545-1964											
<p><b>You will need:</b></p> <ul style="list-style-type: none"> <li>• Tax Information such as Forms W-2, 1099, 1098, 1095.</li> <li>• Social security cards or ITIN letters for all persons on your tax return.</li> <li>• Picture ID (such as valid driver's license) for you and your spouse.</li> </ul> <p style="text-align: center;"><b>Volunteers are trained to provide high quality service and uphold the highest ethical standards. To report unethical behavior to the IRS, email us at <a href="mailto:wi.voltax@irs.gov">wi.voltax@irs.gov</a></b></p>													
<p><b>Part I – Your Personal Information</b> (If you are filing a joint return, enter your names in the same order as last year's return)</p>													
1. Your first name <b>CHARLES</b>	M.I. <b>BALDWIN</b>	Last name <b>BALDWIN</b>	Daytime telephone number <b>YOUR PHONE #</b>	Are you a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
2. Your spouse's first name <b>SHAY</b>	M.I. <b>BALDWIN</b>	Last name <b>BALDWIN</b>	Daytime telephone number <b>YOUR PHONE #</b>	Is your spouse a U.S. citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
3. Mailing address <b>775 BANKS STREET</b>		Apt #	City <b>YOUR CITY</b>	State <b>YS</b>									
4. Your Date of Birth <b>12/03/1981</b>	5. Your job title <b>CUSTOMER SERVICE REP</b>	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 <b>06/10/1985</b>	8. Your spouse's job title <b>CASHIER</b>	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 as a dependent? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unsure													
11. Have you, your spouse, or dependents been a victim of tax related identity theft or been issued an Identity Protection PIN? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No													
<b>Part II – Marital Status and Household Information</b>													
1. As of December 31, 2018, what was your marital status?													
<input type="checkbox"/> Never Married (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 2018? <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													
<b>To be completed by a Certified Volunteer Preparer</b>													
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 U.S., Canada, or Mexico last year (yes/no)	Single or Married as of 12/31/18 (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 \$4,150 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>NATHANIEL BALDWIN</b>	(b) <b>04/04/2004</b>	(c) <b>SON</b>	(d) <b>12</b>	(e) <b>YES</b>	(f) <b>YES</b>	(g) <b>S</b>	(h) <b>YES</b>	(i) <b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>
<b>KARLY BALDWIN</b>	<b>04/29/2006</b>	<b>DAUGHTER</b>	<b>12</b>	<b>YES</b>	<b>YES</b>	<b>S</b>	<b>YES</b>	<b>NO</b>	<b>NO</b>	<b>NO</b>	<b>YES</b>	<b>YES</b>	<b>YES</b>

Check appropriate box for each question in each section				Page 3
Yes	No	Unsure	<b>Part VI - Health Care Coverage - Last year, did you, your spouse, or dependent(s)</b>	
<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?	

Form **1095-A****Health Insurance Marketplace Statement** VOID

OMB No. 1545-2232

Department of the Treasury  
Internal Revenue Service▶ Do not attach to your tax return. Keep for your records.  
▶ Go to [www.irs.gov/Form1095A](http://www.irs.gov/Form1095A) for instructions and the latest information. CORRECTED**2018****Part I Recipient Information**

1 Marketplace identifier <b>XXXXX</b>	2 Marketplace-assigned policy number <b>XXXXX</b>	3 Policy issuer's name <b>XXXXXXXXXXXX</b>
4 Recipient's name <b>CHARLES BALDWIN</b>	5 Recipient's SSN <b>609-00-XXXX</b>	6 Recipient's date of birth <b>12/03/1981</b>
7 Recipient's spouse's name <b>SHAY BALDWIN</b>	8 Recipient's spouse's SSN <b>610-00-XXXX</b>	9 Recipient's spouse's date of birth <b>06/10/1985</b>
10 Policy start date <b>03/01/2018</b>	11 Policy termination date <b>12/31/2018</b>	12 Street address (including apartment no.) <b>775 BANKS ST</b>
13 City or town <b>YOUR CITY</b>	14 State or province <b>YOUR STATE</b>	15 Country and ZIP or foreign postal code <b>YOUR ZIP</b>

**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	<b>CHARLES BALDWIN</b>	<b>609-00-XXXX</b>	<b>12/03/1981</b>	<b>03/01/2018</b>	<b>12/31/2018</b>
17	<b>SHAY BALDWIN</b>	<b>610-00-XXXX</b>	<b>06/10/1985</b>	<b>03/01/2018</b>	<b>12/31/2018</b>
18	<b>NATHANIEL BALDWIN</b>	<b>611-00-XXXX</b>	<b>04/04/2004</b>	<b>03/01/2018</b>	<b>12/31/2018</b>
19	<b>KARLY BALDWIN</b>	<b>612-00-XXXX</b>	<b>04/29/2006</b>	<b>03/01/2018</b>	<b>12/31/2018</b>
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	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
24 April	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
25 May	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
26 June	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
27 July	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
28 August	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
29 September	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
30 October	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
31 November	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
32 December	<b>\$789.00</b>	<b>\$789.00</b>	<b>\$607.00</b>
33 Annual Totals	<b>\$7,101.00</b>	<b>\$7,101.00</b>	<b>\$5,463.00</b>

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

Cat. No. 60703Q

Form **1095-A** (2018)

## Results – Approaching the ACA

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

4. (U) I have an exemption granted by the marketplace.

**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	MEC All Year	No MEC	Months with MEC	Months with Exemption	Exempt All Year	Notes
Taxpayer <b>CHARLES</b>			J F <u>M A M J J A S O N D</u> J F M A M J J A S O N D			short coverage gap
Spouse <b>SHAY</b>			J F <u>M A M J J A S O N D</u> J F M A M J J A S O N D			short coverage gap
Dependent <b>NATHANIEL</b>			J F <u>M A M J J A S O N D</u> J F M A M J J A S O N D			short coverage gap
Dependent <b>KARLY</b>			J F <u>M A M J J A S O N D</u> J F M A M J J A S O N D			short coverage gap
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 March through December:

### Health Insurance Questionnaire

Did you or your family have health insurance at any time in 2017?

Yes

No

### Health Insurance Questionnaire

Did you purchase health insurance via HealthCare.gov or a State Marketplace? \*

Yes

No

### Verify Your Household Members

**i** If you have additional family members that are neither a spouse nor a dependent, click "Add a New Household Member."  
If you need to add or remove dependents, [click here to go to Personal Information.](#)

+ Add New Household Member

Name	SSN	Date of Birth
CHARLES BALDWIN	609-00-XXXX	12/3/1981
SHAY BALDWIN	610-00-XXXX	6/10/1985
NATHANIEL BALDWIN	611-00-XXXX	4/4/2004
KARLY BALDWIN	612-00-XXXX	4/29/2006

+ Add New Household Member

## Months Insured

Was your entire household insured for all 12 months of 2017? \*

- Yes  
 No

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

Name	Months Insured
CHARLES BALDWIN	10
SHAY BALDWIN	10
NATHANIEL BALDWIN	10
KARLY BALDWIN	10

Complete the screen below for Charles, Shay, Nathaniel, and Karly indicating the 10 months that each family member had minimum essential coverage.

## Months Insured - CHARLES BALDWIN

Specify the 10 months that CHARLES BALDWIN had minimum essential coverage

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> January            | <input type="checkbox"/> February            | <input checked="" 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 2017? \*

- Yes  
 No

Are you required to repay all of the APTC received? In most cases, the answer is NO. ONLY answer YES if you were not considered lawfully present in the U.S. or you meet the Health Coverage Tax Credit criteria. Note: We will automatically calculate a full repayment of APTC when MAGI is greater than 400 percent of Federal Poverty Line.

- Yes  
 No

Is your household income below 100% of the Federal poverty line, and do you meet all of the requirements under either "Estimated household income at least 100% of the Federal poverty line" or "Alien lawfully present in the United States"?

- Yes  
 No

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

- Yes  
 No

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	\$ 789	\$ 789	\$ 607 ×
April	\$ 789	\$ 789	\$ 607

The dependents did not have any income or filing requirement.

## Household Income

Enter any premium amount paid through a salary reduction agreement that is excluded from gross income. (Note: This entry is included in the Affordability Threshold when determining affordability if applicable. This information is unnecessary if you will not be completing the affordability worksheets.)

## 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

## Health Care Exemptions



You do not qualify for the exemption based on Household or Gross Income below Filing Threshold, but if you or another household member received a Marketplace Issued Exemption Certificate or qualify for a coverage exemption, please refer to the question below.

**Did you qualify for an exemption due to circumstances or receive an exemption certificate from the marketplace?**

Yes

No

The taxpayers are eligible for the Short Coverage Gap for both January and February. Complete the exemption screen below for each member of the family.

## Health Care Exemption

Name of Individual \*

CHARLES BALDWIN 

Do you have a marketplace-issued certificate for this exemption or going to apply for an exemption from the marketplace? \*

- Yes  
 No

Exemption Type on the return

Short gap in coverage 

Indicate full year or specify months for which you qualify to take the exemption. (Note: Selecting "Coverage is Unaffordable" above will prompt the Affordability Worksheet when continuing)

Full Year

January

February

March

April

## Health Coverage Exemptions

 Add another exemption

Name of Individual	Type		
NATHANIEL BALDWIN	B		
KARLY BALDWIN	B		
SHAY BALDWIN	B		
CHARLES BALDWIN	B		

## **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 or Form 1040NR.  
▶ Go to [www.irs.gov/Form8962](http://www.irs.gov/Form8962) for instructions and the latest information.

Name shown on your return

Your social security number

Charles Baldwin

609-00-XXXX

You cannot take 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**

<b>1</b> Tax family size. Enter your tax family size (see instructions)		<b>1</b>	<b>4</b>
<b>2a</b> Modified AGI. Enter your modified AGI (see instructions)	<b>2a</b> 51250		
<b>b</b> Enter the total of your dependents' modified AGI (see instructions)	<b>2b</b> 0		
<b>3</b> Household income. Add the amounts on lines 2a and 2b (see instructions)		<b>3</b>	51250
<b>4</b> 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. <b>a</b> <input type="checkbox"/> Alaska <b>b</b> <input type="checkbox"/> Hawaii <b>c</b> <input type="checkbox"/> Other 48 states and DC		<b>4</b>	24,600
<b>5</b> Household income as a percentage of federal poverty line (see instructions)		<b>5</b>	208 %
<b>6</b> Did you enter 401% on line 5? (See instructions if you entered less than 100%) <input checked="" type="checkbox"/> <b>No.</b> Continue to line 7. <input type="checkbox"/> <b>Yes.</b> 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.			
<b>7</b> Applicable Figure. Using your line 5 percentage, locate your "applicable figure" on the table in the instructions		<b>7</b>	.0662
<b>8a</b> Annual contribution amount. Multiply line 3 by line 7. Round to nearest whole dollar amount	<b>8a</b> 3393		
<b>b</b> Monthly contribution amount. Divide line 8a by 12. Round to nearest whole dollar amount		<b>8b</b>	283

**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)
<b>11</b> 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)
<b>12</b> January						
<b>13</b> February						
<b>14</b> March	789	789	283	506	506	607
<b>15</b> April	789	789	283	506	506	607
<b>16</b> May	789	789	283	506	506	607
<b>17</b> June	789	789	283	506	506	607
<b>18</b> July	789	789	283	506	506	607
<b>19</b> August	789	789	283	506	506	607
<b>20</b> September	789	789	283	506	506	607
<b>21</b> October	789	789	283	506	506	607
<b>22</b> November	789	789	283	506	506	607
<b>23</b> December	789	789	283	506	506	607
<b>24</b> Total premium tax credit. Enter the amount from line 11(e) or add lines 12(e) through 23(e) and enter the total here					<b>24</b> 5060	
<b>25</b> Advance payment of PTC. Enter the amount from line 11(f) or add lines 12(f) through 23(f) and enter the total here						<b>25</b> 6070
<b>26</b> Net premium tax credit. If line 24 is greater than line 25, subtract line 25 from line 24. Enter the difference here and on Schedule 5 (Form 1040), line 70, or Form 1040NR, line 65. If line 24 equals line 25, enter -0-. Stop here. If line 25 is greater than line 24, leave this line blank and continue to line 27						<b>26</b>

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

<b>27</b> Excess advance payment of PTC. If line 25 is greater than line 24, subtract line 24 from line 25. Enter the difference here		<b>27</b>	1010
<b>28</b> Repayment limitation (see instructions)		<b>28</b>	1550
<b>29</b> Excess advance premium tax credit repayment. Enter the smaller of line 27 or line 28 here and on Schedule 2 (Form 1040), line 46, or Form 1040NR, line 44		<b>29</b>	1010

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

Cat. No. 37784Z

Form **8962** (2018)

## Results – Form 1040, Schedule 2

<b>46</b>	Excess advance premium tax credit. Attach Form 8962 . . . . .	<b>46</b>	<b>1010</b>
<b>47</b>	Add lines 38 through 46. This is your tax. Enter here and on Form 1040, line 11 . . . . .	<b>47</b>	

The "Full-year health care coverage or exempt" box is checked.

<input checked="" type="checkbox"/> Full-year health care coverage or exempt (see inst.)
--



# 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 2018 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 test practice problems
  - Lets volunteers prepare test scenario returns for the test/retest



Go to [www.irs.gov](http://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 returns with the assistance of a certified volunteer. Taxpayers complete their own returns 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.**



www.irs.gov

## 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>

#### After You File

- Where's My Refund?
- Refund reductions
- Understanding Your IRS Notice or Letter
- Withholding Calculator
- Keep a copy of your return
- Changing your name or address

#### Make a Payment

- IRS Direct Pay – pay online directly from your bank account
- Other ways you can pay
- Can't pay? Set up a payment agreement
- Do I have to pay estimated taxes?

#### File Your Return

- Validating your electronically filed return
- Need to renew your ITIN?
- Answers to your tax questions
- Find a mailing address for paper returns
- Tax relief in disaster situations

#### Manage Your Tax Info

- Get Transcript
- View your tax account
- Life events can affect your taxes
- Protect your identity
- IRS2Go mobile app

### 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

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