2017 Tax Organizer
Personal and Dependent Information

Personal Information

	Name	SSN	Date of birth	Healthcare coverage ALL year
Taxpayer				
Spouse				

Street address, city, state, and ZIP

	Occupation	Daytime phone	Evening phone	Cell phone
Taxpayer				
Spouse				

Taxpayer email	
Spouse email	

Marital status at the end of 2017

- ☐ Married
- ☐ Married filing separately
- ☐ Single
- ☐ Widow(er) If spouse passed away in 2017 enter the date of death ____________

Taxpayer	Spouse	
☐ Yes ☐ No	☐ Yes ☐ No	Are you blind?
☐ Yes ☐ No	☐ Yes ☐ No	Are you disabled?
☐ Yes ☐ No	☐ Yes ☐ No	Are you a full-time student?
☐ Yes ☐ No	☐ Yes ☐ No	Do you want $3 to go to the Presidential Election Campaign Fund?

Dependent Information

First and last name	SSN	Relationship	Months in home	Date of birth	Disabled	Full-time student	Healthcare coverage ALL year

List dependents required to file a return ____________

Estimates

	Federal		Resident state		Resident city	
	Date paid	Amount	Date paid	Amount	Date paid	Amount
Overpayment applied from 2016						
First quarter						
Second quarter						
Third quarter						
Fourth quarter						
Additional payments						

Appointment Information & Notes

Your 2017 appointment is scheduled for ____________

Notes

Healthcare Coverage Questionnaire

Name: SSN:

Healthcare Information

Member of household for healthcare purposes	Covered the entire year	Covered less than 12 months	No healthcare coverage at all

YES **NO**

☐ ☐ Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?

☐ ☐ Did you pay for healthcare coverage for anyone not listed above?

If you had coverage for any part of the year:

Where was the policy obtained?

Employer / Medicare / Medicaid / Marketplace(Exchange) / Other

If you didn't have coverage part or all of the year:

Answer YES if the following applies to any member of the household

☐ ☐ Was your previous insurance policy cancelled in 2017?

☐ ☐ Was coverage offered by your employer or your spouse's employer?

☐ ☐ Are you a member of a federally recognized Indian tribe?

☐ ☐ Are you eligible for services through an Indian healthcare provider?

☐ ☐ Are you a member of a healthcare sharing ministry?

☐ ☐ Did you live in the United States the entire year?

☐ ☐ Are you enrolled in TRICARE?

☐ ☐ Did you apply for CHIP coverage?

☐ ☐ Do any of the following apply to you? Do NOT indicate which one.

- Became homeless
- Evicted in the past six months, or facing eviction or foreclosure
- Received a shut-off notice from a utility company
- Recently experienced domestic violence
- Recently experienced the death of a close family member
- Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
- Filed for bankruptcy in the last six months
- Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
- Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member

Other Income and Adjustments

Name: SSN:

Other Income

	2017 Taxpayer	2017 Spouse
Scholarships or grants not reported on form W-2		
State income tax refund (attach Forms 1099-G)		
Alimony received		
Unemployment compensation (attach Forms 1099-G)		
Unemployment compensation repaid in 2017		
Social Security Benefits (attach Forms 1099-SSA)		
Railroad Retirement Benefits (attach Forms 1099-RRB)		
Gambling winnings (attach Forms W2-G)		
Alaska Permanent Fund		
Other income:		

Adjustments

	2017 Taxpayer	2017 Spouse
Educator expenses (If you are an educator, enter the amount you paid for classroom supplies)		
Contributions made to a Health Savings Account (HSA)		
Contributions made to a Self-Employed Pension plan (SEP)		
Payments made for Self-Employed Health Insurance for you, your spouse, or dependents		
Alimony paid		
Name: SSN:		
Name: SSN:		
Contributions made to an Individual Retirement Account (IRA)		
Contributions made to a Roth IRA		
Contributions made to a myRA		
Interest paid on a student loan		
Other adjustments:		

Job-related Moving Expenses

	2017
Number of miles from old home to old workplace	
Number of miles from old home to new workplace	
Expenses to move household goods & personal effects and lodging expenses while traveling to your new home (Do not include cost of meals)	

☐ This was a military move

Schedule A - Itemized Deductions

Name: SSN:

Medical and Dental Expenses

Health insurance premiums (paid by you) . . . . ________

Long-term care premiums (you) . . . . ________

Long-term care premiums (your spouse) . . . . ________

Long-term care premiums (dependents) . . . . ________

Mileage driven for medical purposes . . . . ________

Medical and dental expenses

- Doctor, dental, etc . . . . ________
- Prescription medicines . . . . ________
- Insulin . . . . ________
- Glasses and contacts . . . . ________
- Hearing aids . . . . ________
- Braces . . . . ________
- Medical equipment & supplies . . . . ________
- Hospital services . . . . ________
- Laboratory services . . . . ________
- Nursing services . . . . ________
- Other . . . . ________

Taxes Paid

State and local income taxes . . . . ________

Sales tax . . . . ________

Real estate taxes . . . . ________

Personal property taxes . . . . ________

Other taxes (list) ________________ ________

________________ ________

________________ ________

Interest Paid

Mortgage interest paid (attach Form 1098) . . . . ________

Mortgage interest paid to an individual . . . . ________

Paid to:

Name ________________

Address ________________

City, State, ZIP ________________

SSN or EIN ________

Qualified mortgage insurance premiums . . . . ________

Investment interest . . . . ________

Charitable Contributions

Donations to charity	Cash	Noncash	Amount
Church	☐	☐	________
Boy or Girl Scouts	☐	☐	________
Goodwill	☐	☐	________
Red Cross	☐	☐	________
Salvation Army	☐	☐	________
United Way	☐	☐	________
Veterans	☐	☐	________
Hospital	☐	☐	________
University	☐	☐	________
Other	☐	☐	________

Miles driven for charitable purposes ________

Job Expenses & Certain Miscellaneous Deductions

Necessary job expenses you paid that were not reimbursed by your employer

- Safety equipment, tools, & supplies . . . . . . ________
- Uniforms . . . . ________
- Protective clothing (shoes, hardhats, glasses, etc.) ________
- Dues to professional organizations . . . . ________
- Books & subscriptions . . . . ________
- Other . . . . ________

Tax preparation fees . . . . ________

Other nonpersonal expenses related to taxable income

- Safe deposit box fees . . . . ________
- Investment expenses not entered elsewhere . . ________
- Other . . . . ________

Other Miscellaneous Deductions

Amortizable bond premiums . . . . ________

Federal estate tax . . . . ________

Gambling losses . . . . ________

Impairment-related work expenses . . . . ________

Claim repayments . . . . ________

Unrecovered pension investments . . . . ________

Loss from other activities from Schedule K-1 . . . . ________

Ordinary loss debt instrument . . . . ________

Other Information

Name: SSN:

Mortgage Interest

Provide all copies of Form 1098

Lender's name	Mortgage interest received	Mortgage insurance premiums	Real estate taxes paid

Employee Business Expense Not Reimbursed by Your Employer

	NOT reimbursed by your employer	Reimbursed by your employer not included on your W-2
Rural mail carrier expenses		
Parking fees, tolls, local transportation		
Meals & entertainment		
Overnight business travel expenses (Do not include meals & entertainment)		
Other business expenses		

- ☐ You used your persional vehicle for your job during 2017
- ☐ You are a reservist
- ☐ You are a qualified performing artist
- ☐ You are a fee-based state or local government official
- ☐ You are a disabled employee with impairment-related work expenses
- ☐ You are a member of the clergy

Casualties and Thefts

Property description	Property description
Property location	Property location
Date property was damaged or stolen	Date property was damaged or stolen
Cost of property damaged or stolen	Cost of property damaged or stolen
Amount of damage	Amount of damage
Insurance reimbursement	Insurance reimbursement

Other Information

Name: SSN:

Child and Other Dependent Care Expenses

Name of care provider	Address	SSN or EIN	Amount paid

Education Expenses

Provide all copies of Form 1098-T

Student name ____________________ Student name ____________________

Type of expense	Amount	Type of expense	Amount

Student name ____________________ Student name ____________________

Type of expense	Amount	Type of expense	Amount