Health Care Coverage Questionnaire

Name: **SSN:**

Had health care coverage:	For the entire year	For part of the year (Less than 12 months)	No health care coverage at all

YES ☐ NO ☐	Did anyone besides taxpayer or spouse pay for health care coverage for anyone listed above?
YES ☐ NO ☐	Did you pay for health care 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 it applies to any member of the household

YES ☐ NO ☐	Was your previous insurance policy cancelled in 2014?
YES ☐ NO ☐	Do you have an Exemption from the Marketplace (also called the Exchange)?
YES ☐ NO ☐	Was coverage offered by taxpayer's or spouse's employer?
YES ☐ NO ☐	Are you a member of a federally-recognized Indian tribe?
YES ☐ NO ☐	Are you eligible for services through an Indian health care provider?
YES ☐ NO ☐	Are you a member of a health care sharing ministry?
YES ☐ NO ☐	Did you live in the United States the entire year?
YES ☐ NO ☐	Are you enrolled in TRICARE?
YES ☐ NO ☐	Did you apply for CHIP coverage?
YES ☐ NO ☐	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

2014

Health Care Coverage Questionnaire for taxpayer and spouse
(for preparer use)

PRIMARY TAXPAYER

	All Year	January	February	March	April	May	June	July	August	September	October	November	December
Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Employer offered health coverage which was declined													
If YES, what would be the cost for SELF coverage?													
If YES, what would be the cost for FAMILY coverage?													
Would the FAMILY policy have covered the spouse?													

SPOUSE

	All Year	January	February	March	April	May	June	July	August	September	October	November	December
Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Employer offered health coverage which was declined													
If YES, what would be the cost for SELF coverage?													
If YES, what would be the cost for FAMILY coverage?													
Would the FAMILY policy have covered the spouse?													

2014

Health Care Coverage Questionnaire for Dependents
(for preparer use)

	All Year	January	February	March	April	May	June	July	August	September	October	November	December
Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Required to file a return?	YES ☐	NO ☐		AGI of that return?									

	All Year	January	February	March	April	May	June	July	August	September	October	November	December
Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Required to file a return?	YES ☐	NO ☐		AGI of that return?									

	All Year	January	February	March	April	May	June	July	August	September	October	November	December
Insured through Marketplace (Exchange). MUST provide 1095-A													
Had health care coverage from another source													
Was exempt from health care mandate. Has Exemption Certificate Number? If yes, provide number.													
Required to file a return?	YES ☐	NO ☐		AGI of that return?									