

SCHOPPE'S Tax Service, Inc.

508 W TYSON AVE, CAMERON TX 76520

Affordable Care Act (ACA) Questionnaire

If you did not receive a Form 1095-B or 1095-C for 2015, Please complete the sections that pertains to your family.

Section A:

Do you and your family have health insurance coverage in 2015? () YES () NO
If no please sign and date the bottom of this form.

If yes please keep reading

What (if any) health insurance did you or you dependents have in 2014? (Attach a copy of your insurance card.)

1. ___ Medicare
2. ___ Medicaid (Badger Care)
3. ___ Private Employer
4. ___ Private Insurance
5. ___ Government Marketplace
6. ___ Other (Such as Veterans Affairs (VA)) _

List all members of the family. For each member list the months (if any) he or she did not have health insurance. (if a member has health insurance for one day during the month, he or she is treated as having insurance for the entire month)

FAMILY MEMBER

MONTHS NOT COVERED

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Did you purchase your healthcare insurance for you and your family through the Marketplace (Exchange)?
() Yes or () No

If yes, please sign and date the bottom of this form and return to your preparer. **We will need your form 1095A, which you should have received from the Marketplace.**

(Please continue on back)

Section B:

Does your **employer provide your health insurance coverage** for you and your family? () Yes or () No
If the coverage is for self only please note. If the coverage is for you and your family members please tell us who is covered.

Does your employer provided health insurance coverage meet the Minimum Essential Coverage?
() Yes or () No
When did the coverage start and stop for you in 2015?

Does your spouses' employer provide health insurance coverage for your spouse and your family?
() Yes or () No If the coverage is for your spouse only please note. If the coverage is for you and your family members please tell us who is covered.

Does your spouses' employer provided health insurance coverage meet the Minimum Essential Coverage? () Yes or () No
When did the coverage start and stop for your spouse in 2015?

If you are not sure if the Minimum Essential Coverage is being met please inquire with your employer(s).
If your health insurance coverage is provided by your employer or your spouses' employer please sign and date the bottom of this form.

Section C:

Do you **pay for your own health insurance coverage** for you and your family? () Yes or () No
Does your health insurance coverage meet the Minimum Essential Coverage? () Yes or () No
When did the coverage start and stop in 2015? _____

If you are not sure if your health insurance meets the Minimum Essential Coverage you will need to inquire with your health insurance provider.

Please sign and date.

Taxpayer's Signature

Date

Spouse's Signature

Date

Do you meet any of the following criteria for exemption of Tax Penalty (check all that apply)

To determine whether you qualify for an exchange exemption, visit <http://marketplace.cms.gov> to learn more and to get an application for exemption. For a complete list of exemptions, including hardship exemptions, go to www.healthcare.gov/fees-exemptions

- Unaffordable – lowest priced coverage available to you would cost more than 8% of your household income;
- Short coverage gap – you went less than 3 consecutive months w/o coverage;
- You were incarcerated (detained or in jail);
- You were not lawfully present in the U.S. (not a citizen, nor a US National, are living Abroad, or a Resident of a Foreign Country);
- You are a member of a recognized health care sharing ministry;
- You are a member of a recognized religious sect (religious objections to insurance, including Social Security and Medicare);
- You are enrolled in Limited Benefit Medicaid or TRICARE or VA program;
- Your employer has a Fiscal Year Employer Health Insurance Sponsored Plan
- You are a member of an American Indian Tribe;
- You qualify for Hardship Exemption
- You were homeless;
- You were evicted in the last 6 months of 2014 OR you were facing eviction or foreclosure;
- You received a shut-off notice from a utility company (anytime during 2014);
- You experienced domestic violence (spouse, son, daughter, family, neighbor anyone during year 2014);
- You experienced a death of a close family member in 2014;
- You experienced a fire, flood, or other natural or human-caused disaster that caused substantial damage to your property;
- You filed for bankruptcy in the last 6 months of 2014;
- You had medical expenses you couldn't pay in 2013 or 2014 that resulted in substantial debt;
- You experienced unexpected increase in necessary expenses due to caring for ill, disabled, or aging family member;
- You expect to claim a child as a tax dependent who's been denied coverage in Medicaid and CHIP, and another person is required by court order to give medical support to the child;
- You were determined ineligible for Medicaid because your state didn't expand eligibility for Medicaid under the Affordable Care Act;
- Other

TAXPAYER'S STATEMENT

Under penalties of perjury, I declare that that all the above information is true and correct and should be used in completing my tax return. I further understand that any false statement by me and/or my spouse is considered fraud and is punishable under the laws of the United States Government.

Taxpayer:

DATE