Supplemental Tax Questions

Case Name: _____ CRIS-E Case #: _____

	Person 1 (name)	**Person 2 (name)**	**Person 3 (name)**	**Person 4 (name)**	**Person 5 (name)**	**Person 6 (name)**
Does this person expect to file taxes?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If the answer was **YES**:						
How will you file?	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate	☐ Single ☐ Married Jointly ☐ Married Separate
Who do you claim as a dependent, if any?						
Does anyone claim YOU as a dependent?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If the answer was **NO:**						
Will you be claimed as a dependent?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
By whom?						
Do you have 3rd Party Ins?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
If **YES,**						
Insurance Company:						
Type of Coverage:						

(over)

The information above is needed to check your eligibility for help paying for health coverage if you chose to apply. Your information will be checked in our electronic databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency If the information does not match, we may ask you to provide verification. Your signature below gives us your permission to obtain your information electronically, when available.

Signature of each adult in the household (18 and over) that is applying for health coverage is needed below.

_____ date _____

_____ date _____

_____ date _____

_____ date _____

_____ date _____