

# TAXSTAR

## 5-Minute Tax Questionnaire

### Income Tax Preparation Client Information Questionnaire

INSTRUCTIONS: Answer All questions with an answer or a N/A. For Joint Filings, put a "T" before taxpayer's information and an "S" before spouse's information. **TODAY'S DATE:** \_\_\_\_\_  
 If more space is needed, use the space below or attach blank pages.

#### **SECTION 1** TAXPAYER INFORMATION

1	Taxpayer's First Name	MI	Last
2	Social Security Number (or ITIN)	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
3	Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>		
4	Street Address		Apt#
5	City	State	Zip
6	Home Phone	Work Phone	
7	*E-mail	Date of Birth: month                      day                      year	
8	Legally Blind: Yes <input type="checkbox"/> No <input type="checkbox"/>	Occupation	
9	Can you be claimed as a dependent on another's return Yes <input type="checkbox"/> No <input type="checkbox"/>		\$3 to Presidential Campaign Fund Yes <input type="checkbox"/> No <input type="checkbox"/>

10	Spouse's First Name	MI	Last
11	Social Security Number (or ITIN)	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
12	Street Address		Apt#
13	City	State	Zip
14	Home Phone	Work Phone	
15	*E-mail	Date of Birth: month                      day                      year	
16	Legally Blind: Yes <input type="checkbox"/> No <input type="checkbox"/>	Occupation	
17	Can you be claimed as a dependent on another's return Yes <input type="checkbox"/> No <input type="checkbox"/>		\$3 to Presidential Campaign Fund Yes <input type="checkbox"/> No <input type="checkbox"/>

#### **SECTION 2** FILING STATUS

18	Single <input type="checkbox"/> (Never married, unmarried as of December 31, 2020, or legally separated)		
19	Married Filing Jointly <input type="checkbox"/> (Married as of December 31, 2020)		
20	Married Filing Separately <input type="checkbox"/>	Spouse's Name and SS#	
21	Head of Household <input type="checkbox"/> (Leave blank if you do not know if you qualify)		
22	Qualifying Widow(er) <input type="checkbox"/> (Leave blank if you do not know if you qualify)		
23	Did your spouse die in 2018, 2019 or 2020 Yes <input type="checkbox"/> No <input type="checkbox"/>		If so, did you remarry Yes <input type="checkbox"/> No <input type="checkbox"/>

**If additional space is needed, number and insert below, or check \_\_\_\_\_ and continue on a separate sheet**

--	--

Client Information Sheet (continued)

**SECTION 3 DEPENDENT INFORMATION**

24	1 <sup>st</sup> Dependent's First Name	MI	Last
25	Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth
26	Relationship (son, daughter, etc.)	Dependent's gross income in 2020	
27	Number of months they lived in your home in 2020	Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
28	2 <sup>nd</sup> Dependent's First Name	MI	Last
29	Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth
30	Relationship (son, daughter, etc.)	Dependent's gross income in 2020	
31	Number of months they lived in your home in 2020	Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
32	3 <sup>rd</sup> Dependent's First Name	MI	Last
33	Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth
34	Relationship (son, daughter, etc.)	Dependent's gross income in 2020	
35	Number of months they lived in your home in 2020	Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
36	4 <sup>th</sup> Dependent's First Name	MI	Last
37	Social Security Number	<input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Date of birth
38	Relationship (son, daughter, etc.)	Dependent's gross income in 2020	
39	Number of months they lived in your home in 2020	Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	

**SECTION 4 INCOME**

40	Do you have any Social Security Benefits? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
41	Do you have any interest income NOT listed on a 1099INT? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
42	Do you have any dividends from stocks NOT listed on a 1099DIV? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
43	Do you have any income from a business you own? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
44	Did you sell any stocks or bonds in 2020? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
45	Did you have any rental income from property you owned? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
46	Any other income such as prizes, gambling winnings, jury duty, alimony from an ex-spouse, etc.? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
47	Did you receive Unemployment payments in 2020? If Yes, Amount: \$ Any withholding \$
48	* Did you receive the First economic impact payment sent beginning April, 2020? Yes No If Yes, Amt: \$ * Did you receive the Second economic impact payment sent beginning January, 2021? Yes No If Yes, Amt: \$ Did you have dependent children under age 17 in 2020? Yes No If Yes, how many?
49	Was your 2019 earned income more than the 2020 earned income due to job loss or underemployment? Yes No If Yes, amount of 2019 earned income: \$

If additional space is needed, number and insert below, or check and continue on a separate sheet

--	--

Client Information Sheet (continued)

**SECTION 5 DEDUCTIONS**

50	Do you have any child care expenses? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$ Name of Care Provider _____ Phone _____ Address _____ Address _____ Employer I D # or Social Security # _____
51	Do you have any student loan interest deductions? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
52	Do you have any IRA deductions? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
53	Did you pay interest and property taxes on your home? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
54	Did you pay any alimony to an ex-spouse? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
55	Did you have un-reimbursed medical and dental expenses? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Amount: \$
56	RESERVED
57	Did you contribute to Self-employed SEP or SIMPLE plan? No <input type="checkbox"/> Yes <input type="checkbox"/> If yes, Amount: \$

**SECTION 6 GENERAL QUESTIONS**

	<b>Health Insurance (Affordable Care Act)</b>
58	Did you have health insurance for the entire 2020 year? Yes <input type="checkbox"/> No <input type="checkbox"/> If No, check the months you <u>had</u> health insurance coverage: NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/>
59	Did your spouse have health insurance for the entire 2020 year? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> <input type="checkbox"/> If No, check the months in 2020 your spouse <u>had</u> health insurance coverage: NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/>
60	Did your dependents have health insurance for the entire 2020 year? Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/> If No, check the months in 2020 your dependents <u>had</u> health insurance coverage: Dependent #1 NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/> Dependent #2 NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/> Dependent #3 NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/> Dependent #4 NONE <input type="checkbox"/> Jan <input type="checkbox"/> Feb <input type="checkbox"/> Mar <input type="checkbox"/> Apr <input type="checkbox"/> May <input type="checkbox"/> June <input type="checkbox"/> July <input type="checkbox"/> Aug <input type="checkbox"/> Sept <input type="checkbox"/> Oct <input type="checkbox"/> Nov <input type="checkbox"/> Dec <input type="checkbox"/>
61	Do you and/ or a member of your tax household have a coverage exemption granted by the Marketplace? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, Certificate Number: _____
62	Do you and/ or a member of your tax household have a coverage exemption that can be claimed on your tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>
63	*Did you receive an Advance Payment of Premium Tax Credit? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, Amount: \$
64	RESERVED
65	RESERVED
66	Are any dependents listed in SECTION 3 permanently disabled? Yes <input type="checkbox"/> No <input type="checkbox"/>
67	Were you a student at any time during 2020? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes: How long? _____ How much did you pay for tuition and fees? \$ _____ Books and supplies? _____
68	Did you file a federal tax return last year? Yes <input type="checkbox"/> No <input type="checkbox"/> A state tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>
69	Did you itemize your deductions last year? Yes <input type="checkbox"/> No <input type="checkbox"/>



