Date Received: _____
Date Entered:_____
Date Checked:_____
Date Called: _____
Office Use Only

2017 Taxpayer Check-In

Please complete all Applicable Sections

Taxpayer: **Name**:_____
Social Sec. #_____ DOB:_____ **Occupation**:_____

Spouse: **Name**:_____
Social Sec. #_____ DOB:_____ **Occupation**:_____

Mailing Address: _____
City/Village/Township _____ Zip:_____

Telephone Number: Taxpayer: _____
Spouse: _____
Email: _____

Filing Status: Single _____ Head of Household _____
(choose one) Married Filing Jointly _____ Married Filing Separately _____

Dependents you have the *legal right* to claim in 2017:

Name	Date of Birth	Social Sec. #	Relationship	Months in Home in 2017

- **Did EVERYONE on the tax return have health care coverage for the full year of 2017? _____ (Y/N)**
  If you received forms 1095-A, B or C, you **must** provide these forms to us.
  - Is the coverage from your employer? _____
  - Did your employer offer health insurance coverage? _____ (Form 1095-C)
  - Did you receive an advance premium tax credit? _____ (Form 1095-B)
  - Did you qualify for an exemption? _____

- Did you or your spouse receive an **Identity Protection PIN** from the IRS? If so, please provide letter.

- Dependent Care Expenses:

Provider Name	EIN/SS#	Address	Amount
			$

- Real Estate Taxes **paid in 2017** (for any year)
  Home----------→ $ _____
  Other: Explain_____ ----------→ $ _____

- Rent paid for living quarters **in 2017:** $_____X_____Months = $_____.
  - Was heat included? _____ (Y/N)

- Are you able to claim Educator Expenses? **Amount**
  If so, what is the total qualified expenses in 2017? $_____

- Alimony Received/Paid? _____ (Y/N)
  - If yes, what is the name and Social Sec. number of the person whom you received/paid the Alimony. **Name:**_____ **Soc. Sec:**_____

- Medical and Related Expenses: Amount
  - Health insurance premiums (*paid out of pocket*) _____
  - Long-term care insurance premiums _____
  - Out of pocket medical expenses (*other than insurance)* _____

- Charitable Cash Contributions: Please include any receipts for single contributions over $250.

Organization	Amount
_____	_____
_____	_____

- Charitable **NON-CASH** Contributions: Please include receipts.

- Miscellaneous Expenses: Amount
  - Un-reimbursed business expenses (Provide Detail) _____
  - Other (Provide Detail) _____

- Education Expenses: Amount
  - Student loan interest (include form 1098-E) _____
  - Tuition expense (include form 1098-T) _____
  - Books, Supplies, Etc. _____

- Do you own or partially own a business or rental property _____ (Y/N). If yes, please discuss with a staff member of Breunig CPA, LLC.

- Purchases on internet, mail order, or other out-of-state purchases that you **DID NOT** pay sales tax on? $_____ x 5% = _____ (we will do calculation for you)

- Did you pay **Estimated Tax Payments**? If so, amounts paid and dates of payments are required.

- Do you have any foreign bank accounts? _____ (Y/N)

- Do you wish to receive your refund electronically? _____ (Y/N)
- Do you wish to pay your balance due electronically _____ (Y/N)
  If yes, please supply a voided check and/or the following information:

Routing Number	Account Number	Name of Bank	Checking or Savings	Date of Payment (if applicable)
_____	_____	_____	_____	_____

I verify that all the above information is accurate

Signature: _____ Date: _____