Healthcare Coverage Questionnaire

Name: tax client s SSN: ***-**-****

Healthcare Information

Member of household for healthcare purposes	Covered the entire year	Covered less than 12 months	No healthcare coverage at all

YES NO

☐ ☐ Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?

☐ ☐ Did you pay for healthcare 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 the following applies to any member of the household

☐ ☐ Was your previous insurance policy cancelled in 2017?

☐ ☐ Was coverage offered by your employer or your spouse's employer?

☐ ☐ Are you a member of a federally recognized Indian tribe?

☐ ☐ Are you eligible for services through an Indian healthcare provider?

☐ ☐ Are you a member of a healthcare sharing ministry?

☐ ☐ Did you live in the United States the entire year?

☐ ☐ Are you enrolled in TRICARE?

☐ ☐ Did you apply for CHIP coverage?

☐ ☐ 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

SIGNATURE **DATE**