



ATCAA

Amador Tuolumne
Community Action Agency

People Helping People

TAX INFORMATION CHECKLIST

IDENTITY VERIFICATION

Identity must be verified to begin preparing tax return. Failure to bring this documentation will result in your appointment being rescheduled.

____ Photo ID (both husband and wife if filing a joint return. Acceptable ID includes a State Issued Driver's License. School ID (with a photo), Military ID, VISA or passport, National ID.

____ Valid Social Security Card or ITIN card for every person listed on the tax return. Acceptable substitutes are Form SSA1099 or a Medicare card that includes the letter "A" after the SSN.

____ Bank routing numbers and account numbers for direct deposit or debit. (This is optional)

DID YOU WORK LAST YEAR?

____ Form W-2 ____ Form 1099-NEC ____ Form 1099-G (Unemployment wages)

____ Form W-2G

ARE YOU RETIRED OR NOT IN THE WORKFORCE?

____ Social Security (SSA-1099) or Railroad Retirement Benefits

____ Retirement income or payments from pensions

____ Interest and dividend statements from banks (Form 1099-INT or 1099-DIV).

WERE YOU OR YOUR DEPENDANT ENROLLED IN COLLEGE?

____ Form 1098-T ____ Student Loan Interest form 1098-E ____ Scholarship and College Expenses

DID YOU HAVE OTHER INCOME AND/OR EXPENSES?

____ Mortgage interest Form 1098 ____ Gambling, lottery, or other income

____ Total paid for day care and the day care provider's identifying number.

____ A copy of previous years return if you had a capitol gain or loss carryover (Line item 7 on your IRS return.

____ Medical Insurance from 1095-A, 1095-B or 1095-c. You will need these for your state return.

____ If you have Covered California, you must have a 1095 to begin preparing the return.

Amador Tuolumne Community Action Agency
Client Intake Form

Client's Information

Service you are applying for today: Free Tax Preparation

First Name		Middle		Last Name		Suffix
Date of Birth (mm/dd/yyyy)	SSN - -	<input type="checkbox"/> Unknown <input type="checkbox"/> Decline to State	Gender (please circle one) F=Female M=Male O=Other			
Age : <input type="checkbox"/> 0-5 <input type="checkbox"/> 6-13 <input type="checkbox"/> 14-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-59 <input type="checkbox"/> 60-64 <input type="checkbox"/> 65-74 <input type="checkbox"/> 75+						
Ethnicity: <input type="checkbox"/> Hispanic, Latino or Spanish Origins <input type="checkbox"/> Non -Hispanic, Latino or Spanish Origins						
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White/Caucasian <input type="checkbox"/> Other <input type="checkbox"/> Multi-race (two or more of the above)						

Address

Street Address		Apartment Number
City, CA		Zip Code
Mailing Address (if different from above)		
City, CA		Zip Code
Email Address	Home Phone Number	
Cell Phone	Message Phone	

Program Entry

Program Name Tax Preparation Assistance
Household Type: <input type="checkbox"/> Single Person <input type="checkbox"/> Two Adults No Children <input type="checkbox"/> Single Parent, Female <input type="checkbox"/> Single Parent, Male <input type="checkbox"/> Two-Parent Household <input type="checkbox"/> Non-related Adults with Children <input type="checkbox"/> Multigenerational <input type="checkbox"/> Other
Household Size: <input type="checkbox"/> Single Person <input type="checkbox"/> Two <input type="checkbox"/> Three <input type="checkbox"/> Four <input type="checkbox"/> Five <input type="checkbox"/> Six or more

Client Information

Do you have a disabling condition? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Decline to State
Type of health Insurance? <input type="checkbox"/> Medical <input type="checkbox"/> Medicare <input type="checkbox"/> Employment based <input type="checkbox"/> Covered California <input type="checkbox"/> VA Health Care <input type="checkbox"/> State Children's Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Uninsured
Housing Type: <input type="checkbox"/> Own <input type="checkbox"/> Rent/No Subsidy <input type="checkbox"/> Homeless <input type="checkbox"/> Other
Education Level: <input type="checkbox"/> 0-8 Grade <input type="checkbox"/> 9-12 Grade/Non-graduate <input type="checkbox"/> High School Graduate/GED <input type="checkbox"/> 12+ Some College <input type="checkbox"/> 2 or 4 Year College Graduate <input type="checkbox"/> Graduate of other post-secondary
Employment: <input type="checkbox"/> Employed Full-time <input type="checkbox"/> Employed Part-time <input type="checkbox"/> Full/Part-Time Student <input type="checkbox"/> Retired <input type="checkbox"/> Short Term Unemployed (6 months or less) <input type="checkbox"/> Long Term Unemployed (more than 6 months) <input type="checkbox"/> Not in labor force <input type="checkbox"/> Farm Worker <input type="checkbox"/> Migrant Farm Worker <input type="checkbox"/> Seasonal Farm Worker

Please check ALL income sources and the amount you receive MONTHLY

SOURCES OF INCOME			
	Yes	No	Amount
Income from Employment Only	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Social Security Income	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Supplemental Security Income (SSI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
VA Service-Connected Disability Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
VA Non-Service Connected Disability Pension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Private Disability Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Workers Compensation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Retirement Income from Social Security Pension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Child Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Alimony or Other Spousal Support	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Unemployment Insurance	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
TANF	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
General Assistance/Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Total Income			
NON-CASH BENEFITS received in the last 30 days?			
Food Stamps / Supplemental Nutritional Assistance Program (SNAP)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
WIC	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Public Housing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Permanent Supportive Housing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
HUD-VASH	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Childcare Voucher	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

I acknowledge that the information that I have provided is true and correct and I understand my name and other identifying information will not be shared with any agency outside of ATCAA, unless required to do so by law.

Signature _____ Date _____

No person shall be discriminated against in participating, due to age, sex, color, religion, gender, marital status, ancestry, medical condition, physical or mental disability, citizenship or any other consideration made unlawful by state, federal or local laws.

For additional ATCAA services/programs please inquire within or view our website at www.atcaa.org. We can be reached at 223-1485 in Amador County or 533-1397 in Tuolumne County for more information

SUPPLEMENTAL INTAKE SHEET

1. Your Name _____
2. Did the IRS issue you an ID protection PIN? ____ Yes ____ NO If yes, what is the PIN? (Self) _____ (Spouse) _____
3. Are you a US citizen? ____ YES ____ NO If you are not a US citizen, can prove that you permanently live and work in the United States or prove the time you spent in the US in the last 3 years? ____ YES ____ NO
4. Do you have reliable access to a computer/email to access your complete tax return? ____ YES ____ NO
5. The best way to contact you is:
 - a. ____ Email _____
 - b. ____ Text _____
 - c. ____ Cell Phone _____
 - d. ____ Landline _____
6. What days/times are the best to contact you?

7. Did you pay rent in California for at least ½ the year? ____ YES ____ NO
8. Did you (and spouse) live in California for all of 2022? ____ YES ____ NO
9. List any other states that you resided or worked in 2022. List the dates you moved in and out of that state.

10. Please provide a **voided check** OR complete the following:
Bank Name _____ Routing Number _____ Account Number _____
11. Was your income received through IHSS employment? If yes, did you live with the person for whom care was provided? ____ YES ____ NO
12. Did everyone listed on the tax return have health coverage for 12 months in 2022? ____ YES ____ NO

****PLEASE COMPLETE THE FOLLOWING IF YOU ARE SELF-EMPLOYED****

SELF-EMPLOYMENT INCOME (1099-NEC OR SMALL BUSINESS)

1. Profession: _____
2. How much additional income did you receive that is not reported on 1099-NEC or 1099-K? \$ _____
3. List all expenses:

Advertising	Repairs	Insurance
Supplies	Legal or Professional Services	Taxes or Licenses
Office Expenses	Travel	Meals
Entertainment	Rent or Lease	Other

4. Car/truck information:
 - Vehicle type: _____
 - Business Miles: _____
 - Commuting Miles: _____
 - Other Miles: _____
 - Year vehicle placed into service: _____
5. Was your vehicle available for personal use during off duty hours? ____YES ____NO
6. Do you (or your spouse) have another vehicle available for use?
____ YES ____ NO
7. Do you have evidence to support your deductions? ____ YES ____ NO
8. If yes, is the evidence written? ____ YES ____ NO

Additional Notes:

The following expenses are Out of our Scope of Service

- | | | |
|------------------------|---------------------------|----------------|
| Expenses over \$35,000 | Employee Benefit Programs | Contract Labor |
| Depreciation | Depletion | Wages |
| Mortgage Interest | Pension & Profit Sharing | |

****PLEASE COMPLETE THE FOLLOWING IF YOU HAVE RETIREMENT INCOME****

RETIREMENT INCOME (1099-R)

1. Did you open or close any retirement accounts in 2022? If yes, please list accounts and indicate whether they were opened or closed.

2. Were any of the accounts an early distribution? If yes, what was the money used for?

3. Please complete if a taxable amount is not determined and the simplified method is going to be used.

Annuity Start Date	Annuity start date	Age of recipient at start date
<input type="text"/>	<input type="text"/>	<input type="text"/>
Amount Previously Recovered		Age of spouse at start date
<input type="text"/>		<input type="text"/>

****PLEASE COMPLETE THE FOLLOWING IF YOU OR YOUR DEPENDENT HAVE EDUCATIONAL EXPENSES****

EDUCATIONAL EXPENSES OR SCHOLARSHIP INCOME

1. School Name: _____
2. Has the American Opportunity Credit been claimed for this student for any 4 tax years before 2022? _____ YES _____ NO
3. Did the student complete the first four years of postsecondary ed before 2022?
_____ YES _____ NO
4. Was the student convicted, before the end of 2022 of a felony for possession or distribution of a controlled substance? _____ YES _____ NO
5. Please list any expenses not listed on form 1098-T or account statement (Books, supplies, etc.)

6. Pell Grant amount: _____
7. Other Grants or Scholarships: _____
8. Did you have a student loan forgiven? _____ YES _____ NO
 - a. Amount \$ _____

****PLEASE COMPLETE THE FOLLOWING IF YOU HAVE A HEALTH SAVINGS ACCOUNT****

HEALTH SAVINGS ACCOUNTS

1. Did you, or your family members make any contributions other than what is listed on your W-2 box 12 (code W)? If yes, please give the amount?
 - a. \$ _____

2. Did you receive any distributions listed on Form 1099-SA? If yes, what amount of the distribution was used towards qualified medical expenses?
 - a. \$ _____

3. Did your plan cover just you (self-only plan) or other family members (family Plan)

****PLEASE COMPLETE THE FOLLOWING IF YOU HAVE ITEMIZED DEDUCTIONS****

ADDITIONAL ITEMIZED DEDUCTIONS

Please list totals paid OUT OF POCKET for the expenses. These expenses may or may not be used based on income requirements. **Please DO NOT bring receipts to tax appointments. Receipts are used as verification of information provided below in the event of an audit. In most cases, Medical and Dental expenses can only be deducted if they exceed 7.5% of your income.**

1. Medical Insurance premiums: _____
2. Paid to doctors/dentists: _____
3. Prescriptions: _____
4. X-rays, lab work, etc.: _____
5. Nursing help: _____
6. Hospital care: _____
7. Medical aids: _____
8. Medical Miles driven: _____
9. Other: _____
 - a. Please explain other _____

10. Charitable donations: (Please list amount organization and description under cash or non-cash donations) Receipts are required for non-cash donations over \$499. Bring receipts if you have more than one donation.

Cash _____ non-cash: _____

Donated to: _____ Donated to: _____

Additional deductions:

**Amador Tuolumne Community Action Agency (ATCAA)
10590 Highway 88, Jackson, CA 95642**



**Amador Tuolumne Community Action Agency (ATCAA)
427 N Highway 49 #305, Sonora, CA 95370**



Tax Phone 209-268-6232 Email: Tax@ATCAA.ORG