

Do not return this form to the Vermont Department of Taxes. You must retain this form for your records for three years.

VT Form HC-1 HEALTH CARE CONTRIBUTIONS WORKSHEET

Employer FEIN	Quarter / Year
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Uncovered Employee Count:

Did you have 5 or more full-time equivalent (FTE) employees who were all age 18 and older in the previous quarter? Yes No

- If you answered **NO**, check this box to certify no Health Care Fund Contributions will be due for this quarter. Also, check the box on Form WHT-436, Line 6.
- If you answered **YES**, complete Section 1 **or** 2 below (not both) depending on the health care coverage offered by your company.

Note: For Sections 1 and 2, do not report more than 520 hours for any individual employee, no matter how many actual hours the employee worked during the calendar quarter.

Section 1: Complete this if you **do not** offer to pay any part of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by **all** employees you employed during the reporting quarter and continue to "Section 3: Calculations Section," Line A. _____

Section 1: Total hours of uncovered employees

Section 2: Complete this if you **do** offer to pay part or all of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by all employees in each of the following two categories:

1. Employees who are offered and eligible for coverage but choose **not** to accept the coverage and have no other health care coverage **or** have Medicaid **or** who are full-time employees and have health care coverage as individuals through the Vermont Health Benefit Exchange.
 2. Employees who are **not** eligible for the health care coverage offered to any other employees. You may exclude hours worked by a seasonal or part-time employee **as long as** you offer health care coverage to all regular, full-time employees, **and** the employee is covered by a plan other than Medicaid.
- Section 2, Line 1:** Hours worked by employees offered coverage but did not accept.
- Section 2, Line 2:** Hours worked by employees not offered coverage.

Section 3: Calculations Section

- A. Enter the total hours worked by all employees entered in Section 1 **or** the total of Lines 1 and 2 in Section 2. **NOTE: If the total is a partial hour, round down to the nearest hour.** A. _____
- B. Divide the number of hours on Line A by 520. This is your **unadjusted** FTE count. **NOTE: Round down to the nearest whole number.** B. _____
- C. Number of exempted FTEs. C. 4
- D. Subtract Line C from Line B. This is your **adjusted** and reportable FTE count. Enter this amount on Form WHT-436, Line 7. If equal to or less than zero, report -0-. D. _____
- E. Multiply Line D by the appropriate amount shown in the table below. **This is your quarterly Health Care Contribution.** Enter this amount on Form WHT-436, Line 8, even if -0-. E. _____

HCC Premium per FTE Exemption (Line E)		
Quarter Ending Date	HCC Premium	Use this HCC Premium amount for the calculation on Line E above.
03/31/2022 - 12/31/2022	\$213.47	
03/31/2023 - 12/31/2023	\$238.26	
03/31/2024 - 12/31/2024	\$268.24	



VT Form WHT-436	QUARTERLY WITHHOLDING RECONCILIATION and HEALTH CARE CONTRIBUTION
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Business Name			Federal ID Number		
Address			Vermont Account ID		
City	State	ZIP Code	For Department Use Only		
Foreign Country (if not United States)					
Reporting Period - Check only ONE. If due date falls on a weekend or holiday, return is due the next business day.					Year being reported (YYYY)
<input type="checkbox"/> JAN - MAR (due Apr. 25)		<input type="checkbox"/> APR - JUN (due Jul. 25)		<input type="checkbox"/> JUL - SEP (due Oct. 25)	
			<input type="checkbox"/> OCT - DEC (due Jan. 25)		

- A. Number of full-time employees as of the last day of this quarter... **A.** _____
- B. Number of part-time employees as of the last day of this quarter... **B.** _____
- C. Check here if this is an AMENDED return. **C.**

PART I WAGE WITHHOLDING

1. Total Vermont wages paid this quarter **1.** _____
2. Total Vermont tax withheld from wages this quarter..... **2.** _____

PART II NONWAGE WITHHOLDING

3. Total nonwage payments subject to withholding
 this quarter **3.** _____
4. Total Vermont tax withheld from nonwage payments this quarter **4.** _____
5. **Total Vermont tax withheld this quarter** (Add Lines 2 and 4) **5.** _____

PART III HEALTH CARE CONTRIBUTIONS

6. Check here to certify that no Health Care Contribution is due based on the rules governing this reporting.
7. Adjusted Uncovered FTE (from Form HC-1,
 Health Care Contributions Worksheet, Line D)..... **7.** _____
8. Total Health Care Contributions Due (from Form HC-1, Line E)..... **8.** _____

PART IV BALANCE

9. Total due (Add Lines 5 and 8)..... **9.** _____
10. Vermont withholding tax already paid this quarter **10.** _____
11. **Refund** (If Line 10 is greater than Line 9, subtract Line 9 from Line 10.)..... **11.** _____
12. **TOTAL Withholding Tax and Health Care Contributions Due**
 (If Line 9 is greater than Line 10, subtract Line 10 from Line 9.) **12.** _____

PART V SIGNATURE

I hereby certify that I have examined this return and to the best of my knowledge and belief it is true, correct, and complete.			
Signature of Officer or Authorized Agent	Date	Preparer's Signature	Date
Title	Telephone Number	Firm's name (or yours, if self-employed) and address	

<input type="checkbox"/> Check here if authorizing the Vermont Department of Taxes to discuss this return and attachments with your preparer.	Preparer's Telephone Number	Preparer's PTIN or EIN
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