Vermont Department of Taxes PO Box 547 Montpelier, VT 05601-0547
Phone: (802) 828-2551

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

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. . . . _____

Section 2, Line 1: Hours worked by employees offered coverage but did not accept.

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 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 11. 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 12, even if -0-. . . . . **E.** _____

HCC Premium per FTE Exemption (Line E)

Quarter Ending Date	HCC Premium	
03/31/2023 - 12/31/2023	$238.26	Use this HCC Premium amount for the calculation on Line E above.
03/31/2024 - 12/31/2024	$268.24	
03/31/2025 - 12/31/2025	$296.89	

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VT Form
WHT-436

QUARTERLY WITHHOLDING RECONCILIATION and REQUIRED CONTRIBUTIONS

* 2 4 4 3 6 1 1 0 0 *

☐ Check here if this is an **AMENDED** return

Business Name			Federal ID Number
Address			Vermont Account ID WHT-
City	State	ZIP Code	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)

☐ **JAN - MAR** (due Apr. 25) ☐ **APR - JUN** (due Jul. 25) ☐ **JUL - SEP** (due Oct. 25) ☐ **OCT - DEC** (due Jan. 25)

A. Number of employees as of the last day of this quarter. Full-time _____ Part-time _____

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 CHILD CARE CONTRIBUTIONS

6. ☐ Check here to certify that no Child Care Contribution is due based on the rules governing this reporting.

7. Total wages subject to Child Care Contribution (see instructions) . . . . . **7.** _____.____

8. Child Care Contributions due. (Multiply Line 7 by 0.44% (0.0044) . . . . . **8.** _____.____

9. Amount of Child Care Contributions contributed by employees . . . . . **9.** _____.____

PART IV HEALTH CARE CONTRIBUTIONS

10. ☐ Check here to certify that no Health Care Contribution is due based on the rules governing this reporting.

11. Adjusted Uncovered FTE (from Form HC-1, Health Care Contributions Worksheet, Line D) . . **11.** _____

12. Total Health Care Contributions Due (from Form HC-1, Line E) . . . . . **12.** _____.____

PART V BALANCE

13. Total due (Add Lines 5, 8, and 12) . . . . . **13.** _____.____

14. Vermont withholding tax and contributions already paid this quarter . . . . . **14.** _____.____

15. **Refund** (If Line 14 is greater than Line 13, subtract Line 13 from Line 14.) . . . . . **15.** _____.____

16. **TOTAL Withholding Tax, Child Care Contributions, and Health Care Contributions Due** (If Line 13 is greater than Line 14, subtract Line 14 from Line 13.) . . . . . **16.** _____.____

PART VI 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 _____

Title _____ Telephone Number _____

Preparer's Signature _____ Date _____

Firm's name (or yours, if self-employed) and address _____

☐ 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 _____

5454

Form WHT-436
Page 1 of 1
Rev. 06/24

Clear period info only | Clear ALL fields | Save and go to Important Printing Instructions | Save and Print