Government of the District of Columbia

# 2020 Schedule HSR SUB DC Health Care Shared Responsibility

2 0 0 4 0 5 S 1 0 0 0 1

Unless Instructed otherwise- if you fill any part of this schedule, attach it to your D-40

SOFTWARE DEVELOPER USE ONLY VENDOR ID # 1234

## Personal information

Your daytime telephone number 9999999999

| Your taxpayer identification number (TIN) | *and* Date of Birth (MMDDYYYY) | Spouse's/registered domestic partner's TIN | *and* Date of Birth (MMDDYYYY) |
|---|---|---|---|
| 999999999 | 99999999 | 999999999 | 99999999 |

| Your first name | M.I. | Last name |
|---|---|---|
| XXXXXXXXXXXXXXX | X | XXXXXXXXXXXXXXXXXXXX |

| Spouse's/registered domestic partner's first name | M.I. | Last name |
|---|---|---|
| XXXXXXXXXXXXXXX | X | XXXXXXXXXXXXXXXXXXXX |

Mailing address (number, street and suite/apartment number if applicable)

99999XXXXXXXXXXXXXXXXXXXXXXXXX
99999XXXXXXXXXXXXXXXXXXXXXXXXX

| City | State | Zip Code +4 |
|---|---|---|
| XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | XX | 999999999 |

## PART I Do you have qualifying health coverage?

1 Did you and, if applicable, all members of your health care shared responsibility family, have qualifying health coverage for every month in 2020?

X **Yes. STOP. You do not owe a health care shared responsibility payment. Enter zero on Line 28 of your D-40.**
X **No. If you answered No, complete Part II.**

## PART II Do you have an exemption?

2 Can someone else claim you as a dependent on their federal income tax return for 2020?

X **Yes. STOP. You do not owe a health care shared responsibility payment.**
X **No.**

3 Was your federal adjusted gross income below the applicable filing threshold for your filing status for 2020? *See instructions.*

X **Yes. STOP. You do not owe a health care shared responsibility payment.**
X **No.**

4 Was your federal adjusted gross income, reported on your D-40, Line 4 for 2020, equal to or less than $27,728?

X **Yes. STOP. You do not owe a health care shared responsibility payment.**
X **No.**

**If you answered Yes to any of questions 2 - 4, enter zero on Line 28 of your D-40. If not, continue by answering questions 5 - 6.**

5 Do you affirm under the penalties of perjury that you or any member of your health care shared responsibility family lacked qualifying health coverage in 2020 on the basis of a sincerely held religious belief during the entire taxable year?

X **Yes. You must complete Part III before completing Part IV.**
X **No.**

6 Are you claiming an exemption (other than a sincerely held religious belief) for at least one month for 2020 for yourself or any member of your health care shared responsibility family?

X **Yes. You must complete Part III before completing Part IV.**
X **No.**

**After answering questions 5 - 6, complete Part IV to determine the amount to enter on Line 28 of your D-40. If you answered yes to question 5 or 6, you must also complete Part III.**

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*Enter your lastname* XXXXXXXXXXXXXXXXXXXX

*Enter your taxpayer identification number (TIN)* 999999999

## PART III What coverage exemptions are you claiming for members of your shared responsibility family and for how many months?

| | Name of Individual | Taxpayer Identification Number (TIN) | Exemption Type | Number of Exempt Months Claimed |
|---|---|---|---|---|
| 7 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |
| 8 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |
| 9 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |
| 10 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |
| 11 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |
| 12 | First name and M.I. XXXXXXXXXXXX X<br>Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | 999999999 | X | XX |



## PART IV Complete the applicable worksheets before completing Part IV.

*Roundcents tonearest dollar. If amount is zero,leave line blank.*

| | | | |
|---|---|---|---|
| 13 | Enter flat dollar amount (see Worksheet A-1, Line 5 or Worksheet A-2, Line 7)..... | 13 | 9999999.00 |
| 14 | Enter the percentage income amount (see Worksheet B-1, Line 4 or Worksheet B-2, Line 14)..... | 14 | 9999999.00 |
| 15 | Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the same, enter that number.)..... | 15 | 9999999.00 |
| 16 | Enter the District Average Bronze Plan Premium (see Worksheet C-1, Line 2 or Worksheet C-2, Line 2)..... | 16 | 9999999.00 |
| 17 | Enter the smaller of Line 15 or Line 16 here and on D-40, Line 28..... | 17 | 9999999.00 |