



Form 1 Massachusetts Resident Income Tax Return

2016

Form fields for personal information: FIRST NAME (Plotting for), M.I., LAST NAME (Jailbreak), SPOUSE'S FIRST NAME, M.I., LAST NAME, ADDRESS, CITY/TOWN/POST OFFICE/FOREIGN COUNTRY, STATE, ZIP + 4, and SOCIAL SECURITY NUMBERS.

Fill in if (see instructions): Original return, Amended return, Amended return due to federal change, State Election Campaign Fund, and veteran of U.S. armed forces.

Income summary section: Total federal income (35,500.00) and Federal adjusted gross income (35,500.00).

1 FILING STATUS: Single, Married filing joint return (checked), Married filing separate return, Head of household.

2 EXEMPTIONS: Personal exemptions (8,800.00), Number of dependents (1,000.00), Age 65 or over before 2017, Blindness, Medical/Dental, Adoption, and TOTAL EXEMPTIONS (9,800.00).

INCOME section: 3 Wages, salaries, tips and other employee compensation; 4 Taxable pensions and annuities; 5 Massachusetts bank interest; 6 Business/profession or farm income/loss; 7 Rental, royalty, REMIC, partnership, S corporation, trust income/loss; 8 Unemployment compensation and Massachusetts state lottery winnings; 9 Other income.

SIGN HERE. Under penalties of perjury, I declare that to the best of my knowledge and belief this return and enclosures are true, correct and complete.

Signature and preparer information fields: Your signature, Date, Print paid preparer's name, Preparer's SSN or PTIN, Spouse's signature, Date, Paid preparer's phone, Paid preparer's EIN, and a checkbox for 'May DOR discuss this return with the preparer?'.

Attach, with a single staple, state copy of Forms W-2, W-2G and 1099 (showing Massachusetts withholding).



FULL-YEAR RESIDENTS AND CERTAIN PART-YEAR RESIDENTS MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH RETURN.

FIRST NAME, M.I., LAST NAME, SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2016

1 a. Date of birth, b. Spouse's date of birth, c. Family size

2 Federal adjusted gross income

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s).

3a You: Full-year MCC, Part-year MCC, No MCC/None
3b Spouse: Full-year MCC, Part-year MCC, No MCC/None

Note: See instructions if, during 2016, you turned 18, you were a part-year resident or a taxpayer was deceased.

If you filled in "Full-year MCC" or "Part-year MCC", go to line 4. If you filled in "No MCC/None", go to line 6.

4 Indicate the health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements in which you were enrolled in 2016.

4a Private insurance, including ConnectorCare
4b MassHealth
4c Medicare
4d U.S. Military
4e Other government program

4f YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO., SUBSCRIBER NUMBER

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO., SUBSCRIBER NUMBER

4g SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM FOR SPOUSE

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO., SPOUSE'S SUBSCRIBER NUMBER

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY FOR SPOUSE

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO., SPOUSE'S SUBSCRIBER NUMBER

5 If you had health insurance that met MCC requirements for the full-year, including private insurance, MassHealth or ConnectorCare, you are not subject to a penalty.

If you had Medicare (including a replacement or supplemental plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance at any point during 2016, you are not subject to a penalty.

SKIP THE REMAINDER OF THIS SCHEDULE AND CONTINUE COMPLETING YOUR TAX RETURN.

If you filled in the "Part-year MCC" or "No MCC/None" in line 3, you must complete line 6.

BE SURE YOU FILLED IN LINES 2 & 3 ABOVE. YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

Attach, with a single staple, copy of Form MA 1099-HC, if applicable.

IF YOU HAD HEALTH INSURANCE THAT MET MCC REQUIREMENTS FOR THE FULL YEAR, INCLUDING PRIVATE INSURANCE, MASSHEALTH OR CONNECTORCARE, OR IF YOU HAD MEDICARE, U.S. MILITARY OR OTHER GOVERNMENT INSURANCE AT ANY POINT DURING 2016, YOU ARE NOT SUBJECT TO A PENALTY. SKIP THE REMAINDER OF SCHEDULE HC AND CONTINUE COMPLETING YOUR TAX RETURN.



FIRST NAME

M.I. LAST NAME

SOCIAL SECURITY NUMBER

Schedule HC Uninsured for All or Part of 2016

Do NOT complete if you are not subject to a penalty.

6 Was your income in 2016 at or below 150% of the federal poverty level (see worksheet)? ▶ **6** Yes No

If you answer **Yes**, **YOU ARE NOT SUBJECT TO A PENALTY IN 2016. SKIP THE REMAINDER OF THIS SCHEDULE AND COMPLETE YOUR TAX RETURN.** If you answer **No** and you were enrolled in a health insurance plan that met the MCC requirements for part, but not all, of 2016, go to line 7. If you answer **No** and you had no insurance or you were enrolled in a plan that did not meet the MCC requirements during the period that the mandate applied, go to line 8a.

7 Complete this section **only** if you, and/or your spouse if married filing jointly, were enrolled in a health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements for part, but not all of 2016. Fill in the ovals below for the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in the ovals for the months you were covered by a plan that met the MCC requirements at least **15 days or more**. If, during 2016, you **turned 18**, you were a **part-year resident** or a taxpayer was **deceased**, fill in the oval(s) below for the month(s) that met the MCC requirements during the period that the mandate applied. See instructions.

You may **only** fill in the oval(s) for the month(s) you had health insurance that met MCC requirements. If you had health insurance, but it did not meet MCC requirements, you must skip this section and go to line 8a.

MONTHS COVERED BY HEALTH INSURANCE THAT MET MINIMUM CREDITABLE COVERAGE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
YOU:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SPOUSE:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you had four or more consecutive months either with no insurance or insurance that did not meet the MCC requirements (four or more blank ovals in a row), go to line 8a. Otherwise, a penalty does not apply to you in 2016. **YOU ARE NOT SUBJECT TO A PENALTY IN 2016. SKIP THE REMAINDER OF THIS SCHEDULE AND COMPLETE YOUR TAX RETURN.**

Schedule HC Religious Exemption and Certificate of Exemption

Do NOT complete if you are not subject to a penalty.

8 a. RELIGIOUS EXEMPTION. Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs that cause you to object to substantially all forms of treatment covered by health insurance? ▶ **8a** You: Yes No
Spouse: Yes No

If you answer **Yes**, go to line 8b. If you answer **No**, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2016 tax year? ▶ **8b** You: Yes No
Spouse: Yes No

If you answer **No** to line 8b, **YOU ARE NOT SUBJECT TO A PENALTY IN 2016. SKIP THE REMAINDER OF THIS SCHEDULE AND CONTINUE COMPLETING YOUR TAX RETURN.** If you answer **Yes** to line 8b, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

9 CERTIFICATE OF EXEMPTION. Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2016 tax year? ▶ **9** You: Yes No
Spouse: Yes No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2016, issued by the Federal Health Insurance Marketplace, do not enter that information in line 9.

If you answer **Yes**, enter the certificate number below, **YOU ARE NOT SUBJECT TO A PENALTY IN 2016. SKIP THE REMAINDER OF THIS SCHEDULE AND CONTINUE COMPLETING YOUR TAX RETURN.** If you answer **No** to line 9, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR MASSACHUSETTS CERTIFICATE NUMBER

SPOUSE'S MASSACHUSETTS CERTIFICATE NUMBER

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.



FIRST NAME M.I. LAST NAME SOCIAL SECURITY NUMBER

Schedule HC Affordability as Determined By State Guidelines

Do NOT complete if you are not subject to a penalty.

NOTE: This section will require the use of worksheets and tables. You **must** complete the worksheet(s) to determine if health insurance was affordable to you during the 2016 tax year.

- 10** Did your employer offer affordable health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10? **▶ 10** You: Yes No
Spouse: Yes No

If your employer did not offer health insurance that met the minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

- 11** Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11? **▶ 11** You: Yes No
Spouse: Yes No

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

- 12** Were you able to purchase affordable private health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12? **▶ 12** You: Yes No
Spouse: Yes No

If you answer **No**, you are not subject to a penalty. **CONTINUE COMPLETING YOUR TAX RETURN.** If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

Schedule HC Complete Only If You Are Filing an Appeal

You must complete the Health Care Penalty Worksheet to determine your penalty amount before completing this section.

You may have grounds to appeal if you were unable to obtain affordable insurance that met the minimum creditable coverage requirements in 2016 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. If you believe you have grounds for appealing the penalty, fill in the oval(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the oval below, you (or your spouse if married filing jointly) are authorizing DOR to share information from your tax return, including this schedule, with the Massachusetts Health Connector for purposes of deciding your appeal.

Note: You may also be subject to a separate federal penalty if you were uninsured. Visit irs.gov for more information on the federal requirements.

If you are subject to a federal penalty, you must enter that amount on Form 1, line 35c or Form 1-NR/PY, line 39c.

Important Information If You Are Filing An Appeal:

You will receive a follow-up letter asking you to state your grounds for appeal in writing, and submit supporting documentation. Failure to respond to that letter within the time specified in the letter will lead to dismissal of your appeal and will result in a future assessment of a penalty.

Once your documentation is received, it will be reviewed by the Massachusetts Health Connector and you may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do **not** assess yourself or enter a penalty amount on your Form 1 or Form 1-NR/PY. Also, do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

YOU: I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.

SPOUSE: I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.



FIRST NAME

M.I. LAST NAME

SOCIAL SECURITY NUMBER

Schedule B Interest, Dividends and Certain Capital Gains and Losses

2016

PART 1. INTEREST AND DIVIDEND INCOME

If you received any interest income other than interest from Massachusetts banks, or if you received more than \$1,500 in gross dividend income, or if you have certain capital gains/losses, or any adjustments to interest and dividend income, complete Schedule B (see instructions). Otherwise, enter dividends of \$1,500 or less on Form 1, line 20 or Form 1-NR/PY, line 24. In all cases enter 5.1% interest from Massachusetts banks on Form 1, line 5a or Form 1-NR/PY, line 7a.

1	Total interest income (from U.S. Form 1040 or 1040A, line 8a and line 8b; or Form 1040EZ, line 2) . . . 1	5,000 00
2	Total ordinary dividends (from U.S. Schedule B, Part II, line 6, or U.S. Schedule 1, Part II, line 6. If U.S. Schedule B or U.S. Schedule 1 not filed, from U.S. 1040 or 1040A, line 9a) 2	20,000 00
3	Other interest and dividends not included above (enclose statement) 3	00
4	Total interest and dividends. Add lines 1, 2 and 3 4	25,000 00
5	Total interest from Massachusetts banks (from Form 1, line 5a or Form 1-NR/PY, line 7a) 5	00
6	Other interest and dividends to be excluded (enclose statement) (this includes interest on U.S./ Commonwealth debt obligations and interest and dividends taxed directly to Mass. estates and trusts) 6	00
7	Subtotal: Line 4 minus lines 5 and 6. Not less than "0" 7	25,000 00
8	Allowable deductions from your trade or business (from Mass. Schedule C-2). See instructions 8	00
9	Subtotal: Subtract line 8 from line 7. Not less than "0." If you have no short-term capital gains or losses, net long-term capital losses, long-term gains on collectibles and pre-1996 installment sales, short-term gains or losses from the sale, exchange or involuntary conversion of property used in a trade or business, allowable deductions from your trade or business against short-term capital gains, carryover short-term losses from prior years, or excess exemptions, omit lines 10-37. Enter this amount in line 38 and on Form 1, line 20 or Form 1-NR/PY, line 24, and omit lines 39 and 40. Otherwise, complete Parts 2, 3 and 4 . . . 9	25,000 00

PART 2. SHORT-TERM CAPITAL GAINS/LOSSES & LONG-TERM GAINS ON COLLECTIBLES

10	Short-term capital gains (included in U.S. Schedule D, lines 1 through 5, col. h) 10	00
11	Long-term capital gains on collectibles and pre-1996 installment sales (from Massachusetts Schedule D, line 12) 11	00
12	Gain on the sale, exchange or involuntary conversion of property used in a trade or business and held for one year or less (from U.S. Form 4797) 12	00
13	Add lines 10 through 12 13	00
14	Allowable deductions from your trade or business (from Mass. Schedule C-2). See instructions . . . 14	00
15	Subtotal: Subtract line 14 from line 13. Not less than "0" 15	00
16	Short-term capital losses (included in U.S. Schedule D, lines 1 through 5, col. h) 16	<input checked="" type="checkbox"/> 00
17	Loss on the sale, exchange or involuntary conversion of property used in a trade or business and held for one year or less (from U.S. Form 4797) 17	<input checked="" type="checkbox"/> 00
18	Prior short-term unused losses for years beginning after 1981 (from 2015 Massachusetts Schedule B, line 40) 18	<input checked="" type="checkbox"/> 00
19	Combine lines 15 through 18. If "0" or greater, omit lines 20 through 23 and enter this amount in line 24. If less than "0," complete line 20 19	<input checked="" type="checkbox"/> 00
20	Short-term losses applied against interest and dividends. Enter the smaller of line 9 or line 19 (considered as a positive amount). Not more than \$2,000 20	00

▼ If showing a loss, mark an X in box at left

BE SURE TO COMPLETE SCHEDULE B, PARTS 3 AND 4, ON OTHER SIDE.

