

**Client Tax Organizer**

For the year January 1 – December 31, 20 .

Taxpayer Last Name First Name M.I. Social Security #



Spouse Last Name First Name M.I. Social Security #



**Verification and Signature:**

To the best of my knowledge the enclosed information is correct and includes all income, deductions, and other information necessary for the preparation of this year’s income tax return for which I have adequate records.

Date Date



**Appointment**

Date and time of appointment: Please bring:

• Copies of two preceding years’ tax returns (new clients only)

• All tax documents (W-2s, 1099s, 1099-Rs, K-1s, etc.)

Bring original documents which we will copy and return to you, or legible copies that you can leave with us.

**Credit Card Authorization**

Credit Card #: - - - Expiration Date /

3 digit code located on the back of credit card:

Type of Credit Card: Visa MasterCard (Circle One)

I, (full name as appears on the credit card) authorize Professional Tax Service to charge my credit card for monies I owe Professional Tax Service for services rendered in preparation of my tax return.

Credit Card Billing Address: Street:

City: State:

Zip Code:

Telephone: ( )

        Cardholder’s Signature Date

**Thank you**

**Client Tax Organizer**

  Please complete this Organizer before your appointment. Please enter whole numbers only (no cents.)

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| **1. Personal Information** | | | | | | | | | | | |
|  | Last Name | | First Name, M.I. | | Social Security # | | | Birth Date | | Occupation | |
| Taxpayer |  | |  | |  | | |  | |  | |
| Spouse |  | |  | |  | | |  | |  | |
| Street Address | | | | | | City | | | State | | Zip |
| Home Phone | | Work Phone | | Cell Phone | | | Email | | | | |

  Taxpayer Spouse Marital Status



Blind

Yes No

Yes No Married Will file jointly Yes No

Disabled Yes No

Yes No

Single

Widow(er), Date of Spouse’s Death

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| **2. Dependents (Children & Others)** | | | | | | |
| Name  (As Appears on Social Security card) | Relationship | Date of  Birth | Social Security # | Months Lived With You | Disabled | Full Time  Student |
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| **3. Estimated Taxes Paid** | | | |
|  | Date Paid | Federal | State |
| First Quarter |  |  |  |
| Second Quarter |  |  |  |
| Third Quarter |  |  |  |
| Fourth Quarter |  |  |  |

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| **4. Refund Direct Deposit** | |
| Bank Name |  |
| Banking Routing Number (9-Digit Number) |  |
| Account Number |  |
| Account Type | Checking Savings |

**5. Interest Income**

Please attach 1099-INTs & brokerage statements.



|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Payer | T/S/J | Bank or Credit  Union | U.S. Bonds/  T-Bills | Federal Tax  Withheld | Municipal or  Tax-Exempt |
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| **6. Dividend Income from Mutual Funds and Stocks** | | | | | |
| Please attach 1099-DIVs for each item listed below. | | | | |  |
| Payer | T/S/J | Total ordinary  Dividends  (Box 1a) | Qualified  Dividends  (Box 1b) | Capital Gain  Distribution  (Box 2a) | Federal Tax  Withheld |
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**7. Other Income**

Please list all other income.

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| --- | --- | --- | --- |
| Payer/Source | Taxpayer | Spouse | Federal Tax Withheld |
| Alimony Received |  |  |  |
| Prizes, Bonuses, Awards |  |  |  |
| Jury Duty |  |  |  |
| Worker’s Compensation |  |  |  |
| Social Security Benefits (Taxable Income) |  |  |  |
| Medicare Premiums Withheld |  |  |  |
| Unemployment Compensation Received |  |  |  |
| Unemployment Compensation Repaid |  |  |  |
| Gambling, Lottery |  |  |  |
| Other Income |  |  |  |
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| **8. Medical/Dental Expenses** | | | |
| To be deducted, medical expenses must exceed 7.5% of your adjusted gross income, and then only the amount that exceeds a 7.5% floor is deductible. Example: Your income is $40,000 for the year; your medical expenses must exceed $3,000. | | | |
|  | Amount |  | Amount |
| Acupuncture, Chiropractic |  | Lodging for Away-From-Home Medical Purposes |  |
| Ambulance, Paramedics |  | Long-Term Care Insurance – Taxpayer |  |
| Auto Travel for Medical Purposes | miles | Long-Term Care Insurance – Spouse |  |
| Braces |  | Medical Equipment, Supplies |  |
| Doctors, Dentists (discretionary cosmetic surgery is not deductible) |  | Medical Insurance Premiums (paid by you) |  |
| Glasses, Contact Lenses |  | Nursing Homes, Nursing Care |  |
| Handicapped Modification to Home |  | Parking Fees for Medical Purposes |  |
| Handicapped Placard |  | Prescription Drugs |  |
| Hearing Aid, Batteries |  | Psychotherapy, Psychological Counseling |  |
| Hospital |  | Other: |  |
| Insulin |  |  |  |
| Lab Fees & X-Rays |  | Insurance Reimbursement | ( ) |

**9. Home Mortgage Interest**

IF YOU HAVE PURCHASED, SOLD OR REFINANCED YOUR HOME THIS YEAR, PLEASE BRING YOUR ESCROW PAPERS WITH YOU.

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| Paid to Banks | Amount Paid |
| Mortgage Company: |  |
| Mortgage Company: |  |
| Mortgage Company: |  |
| Home Equity Loan: |  |
| Paid to Individuals |  |
| Name: | Social Security # |
| Address: | Amount Paid: $ |
| Name: | Social Security # |
| Address: | Amount Paid: $ |

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| **10. Taxes Paid** | |
| Real Estate Taxes |  |
| Auto License Fees (vehicle license fee portion only) |  |
| Property taxes on investment property |  |
| Personal property tax – boat, etc. |  |
| State Income Tax (We calculate) |  |
| Other Taxes: |  |
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**11. Alimony Paid**

Do not include amount paid for child support. Child support is not deductible.

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| Name | Social Security Number | Amount Paid |
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| **12. Charitable Contributions** | | | |
| **Cash Contributions** | | | |
| Church |  | | |
| Payroll Deduction |  | | |
| United Way |  | | |
| Cancer Society |  | | |
| Red Cross |  | | |
| Scouts |  | | |
| Other (please list): |  | | |
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| Volunteer (no. of miles) |  | | |
| **Non-Cash Charitable Contributions** | | | |
| Description of Property Donated | | Donee Name | Fair Market Value |
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| **13. Child & Dependent Care Expenses** | | | | | |
| Care must enable you to work (or look for work) or attend school FULL TIME. Care must be for a child under age 13 or a dependent who is physically or mentally incapable of self care. | | | | | |
| Care Provider Name | Address  City, State, Zip | Phone # | Identifying #  SSN or EIN | Amount Paid | Name of child cared  for |
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\*If child care is for more than one child or dependent, please indicate how much was paid for **each** child or dependent.

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| **14. Miscellaneous Itemized Deductions** | | |
|  | Taxpayer | Spouse |
| Business Telephone |  |  |
| Cell Phone |  |  |
| Credential Renewal & Transcripts |  |  |
| Education Expense (Course Work) |  |  |
| Internet/DSL |  |  |
| Job Seeking Expense |  |  |
| Professional Dues (CTA, NEA, etc) |  |  |
| Professional Subscriptions |  |  |
| Safety Deposit Box |  |  |
| Safety Equipment |  |  |
| Tax Return Preparation Fee |  |  |
| Teaching Aids & Supplies |  |  |
| Uniforms & Laundry |  |  |
| Union Dues |  |  |
| Work Tools |  |  |
| Other (please list): |  |  |
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| **15. Education Expenses – College or Other Continuing Education Expenses** | | | |
| Student’s Name | Type of Expense | Year of School | Amount |
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**Student Loan Interest Paid**

Taxpayer: $

Spouse: $

Dependent(s): $