



Form 1 Massachusetts Resident Income Tax Return

2016

Form fields for personal information: FIRST NAME, M.I., LAST NAME, SPOUSE'S FIRST NAME, M.I., LAST NAME, ADDRESS, CITY/TOWN/POST OFFICE/FOREIGN COUNTRY, STATE, ZIP + 4, 1. YOUR SOCIAL SECURITY NUMBER, 2. SPOUSE'S SOCIAL SECURITY NUMBER.

Fill in if (see instructions): Original return, Amended return, Amended return due to federal change, State Election Campaign Fund, Fill in if veteran of U.S. armed forces who served in Operation Enduring Freedom, Iraqi Freedom or Noble Eagle.

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

Line a: Total federal income (from U.S. Forms 1040, line 22; 1040A, line 15; or 1040EZ, line 4)
Line b: Federal adjusted gross income (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4)

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

2 EXEMPTIONS: a. Personal exemptions. b. Number of dependents. c. Age 65 or over before 2017. d. Blindness. e. 1. Medical/Dental, 2. Adoption. f. TOTAL EXEMPTIONS.

INCOME
3 Wages, salaries, tips and other employee compensation
4 Taxable pensions and annuities
5 a. Massachusetts bank interest, b. Exemption amount. If married filing jointly, enter \$200; otherwise, enter \$100
6 Business/profession or farm income/loss
7 If you are reporting rental, royalty, REMIC, partnership, S corporation, trust income/loss, see instructions
8 a. Unemployment compensation. See instructions
b. Massachusetts state lottery winnings
9 Other income (alimony, taxable IRA/Keogh distribution, winnings, fees) from Schedule X, line 5

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.

Your signature, Date, Print paid preparer's name, Preparer's SSN or PTIN, Spouse's signature (if filing jointly), Date, Paid preparer's phone, Paid preparer's EIN, May DOR discuss this return with the preparer?, I do not want my preparer to file my return electronically.



FIRST NAME	M.I.	LAST NAME	SOCIAL SECURITY NUMBER

33 Voluntary fund contributions:

a. Endangered Wildlife Conservation ▶ 33a <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>	d. Massachusetts U.S. Olympic ▶ 33d <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>
b. Organ Transplant ▶ 33b <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>	e. Mass. Military Family Relief ▶ 33e <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>
c. Massachusetts AIDS ▶ 33c <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>	f. Homeless Animal Prevention And Care ▶ 33f <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>
Total. Add lines 33a through 33f 33 <input type="text" value=""/> <input type="text" value=""/> <input type="text" value="0"/> <input type="text" value="0"/>	

34 Use tax due on Internet, mail order and other out-of-state purchases (from worksheet) ▶ 34

35 Health Care penalty. **Not less than "0"** (from worksheet; be sure to enclose Schedule HC):

a. ▶ + b. ▶ - c. ▶ ... a + b - c = 35

You Spouse Federal healthcare penalty

36 **INCOME TAX AFTER CREDITS, CONTRIBUTIONS, USE TAX and HC PENALTY.** Add lines 32–35 ▶ 36

37 Massachusetts income tax withheld (**enclose** all Massachusetts Forms W-2, W-2G, 2-G, PWH-WA, LOA and certain 1099s, if applicable) ▶ 37

38 2015 overpayment applied to your 2016 estimated tax (from 2015 Form 1, line 45 or Form 1-NR/PY, line 50; do not enter 2015 refund) ▶ 38

39 2016 Massachusetts estimated tax payments (**do not include amount in line 38**) ▶ 39

40 Payments made with extension ▶ 40

41 Earned Income Credit:

a. Number of qualifying children ▶ Amount from U.S. return ▶ × .23 = ▶ 41

42 Senior Circuit Breaker Credit (**enclose** Schedule CB) ▶ 42

43 Other refundable credits (from Credit Manager Schedule) ▶ 43

44 **TOTAL.** Add lines 37 through 43 ▶ 44

45 **OVERPAYMENT.** If line 36 is **smaller** than line 44, subtract line 36 from line 44. If line 36 is **larger** than line 44, go to line 48. If line 36 and line 44 are equal, enter "0" in line 47 ▶ 45

46 Amount of overpayment you want **APPLIED to your 2017 ESTIMATED TAX** ▶ 46

47 **THIS IS YOUR REFUND.** Subtract line 46 from line 45.
 Mail to: **Massachusetts DOR, PO Box 7000, Boston, MA 02204** ▶ 47

Direct Deposit of Refund. See instructions. Type of account (you must select one): ▶ Checking Savings

▶ ▶

Routing number (first two digits must be 01–12 or 21–32) Account number

48 **TAX DUE.** Subtract line 44 from line 36. **Pay online at mass.gov/masstaxconnect**, or use Form PV ▶ 48

Pay in full. Write **Social Security number(s)** on lower left corner of check and **be sure to sign check.** Make payable to **Commonwealth of Massachusetts.** Mail to: **Massachusetts DOR, PO Box 7003, Boston, MA 02204.**

Add to total in line 48, if applicable:

Interest ▶ Penalty ▶ M-2210 amount ▶

▶ Exception. Enclose Form M-2210



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). You must fill in an oval. The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. Note: MassHealth, Medicare, and health coverage for U.S. Military, including Veterans Administration and Tri-Care, meet the MCC requirements. If you did not receive a Form MA 1099-HC from your insurer, or you had insurance that did not meet MCC requirements, see the section on MCC requirements in the instructions.
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, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, fill in the oval in line(s) 4f and/or 4g and see instructions. If you were enrolled in private insurance and MassHealth, fill in the ovals, enter your private insurance information in line(s) 4f and/or 4g and go to line 5.

4a Private insurance, including ConnectorCare (complete lines 4f and/or 4g below).
4b MassHealth. Fill in oval(s) and go to line 5.
4c Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5.
4d U.S. Military (including Veterans Administration and Tri-Care). Fill in oval(s) and go to line 5.
4e Other government program (enter the program name(s) only in lines 4f and/or 4g below).
4a You, Spouse
4b You, Spouse
4c You, Spouse
4d You, Spouse
4e You, Spouse

Note: Health Safety Net is not considered insurance or minimum creditable coverage.

4f YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. Fill in if you were not issued Form MA 1099-HC

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

4g SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. Fill in if you were not issued Form MA 1099-HC

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

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

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.