**MARYLAND FORM 502**

**RESIDENT INCOME TAX RETURN**

**2020**

205020050

$

OR FISCAL YEAR BEGINNING _____ 2020, ENDING _____

*Print Using Blue or Black Ink Only*

Your Social Security Number

Spouse's Social Security Number

Your First Name _____ MI ___

Does your name match the name on your social security card? If not, to ensure you get credit for your personal exemptions, contact SSA at 1-800-772-1213 or visit **www.ssa.gov**.

Your Last Name

Spouse's First Name _____ MI ___

Spouse's Last Name

Current Mailing Address Line 1 (**Street No. and Street Name or PO Box**)

Current Mailing Address Line 2 (**Apt No., Suite No., Floor No.**) | City or Town | State | ZIP Code + 4

*Place your W-2 wage and tax statements and ATTACH HERE with one staple. Do not attach check or money order to Form 502. Attach check or money order to Form PV.*

**REQUIRED:** Maryland Physical address of taxing area as of December 31, 2020 or last day of the taxable year for fiscal year taxpayers. **See Instruction 6. Part-year residents see Instruction 26.**

4 Digit Political Subdivision Code (See Instruction 6)     Maryland Political Subdivision (See Instruction 6)

Maryland Physical Address Line 1 (Street No. and Street Name) (No PO Box)

Maryland Physical Address Line 2 (Apt No., Suite No., Floor No.) (No PO Box)

City | MD State | ZIP Code + 4 | Maryland County

**FILING STATUS**

**CHECK ONE BOX ▶**

See Instruction 1 if you are required to file.

1. [ ] Single (If you can be claimed on another person's tax return, use Filing Status 6.)
2. [ ] Married filing joint return or spouse had no income
3. [ ] Married filing separately, Spouse SSN ▶_____
4. [ ] Head of household
5. [ ] Qualifying widow(er) with dependent child
6. [ ] Dependent taxpayer (Enter 0 in Exemption Box (A) - See Instruction 7.)

**PART-YEAR RESIDENT**

See Instruction 26.

**Dates of Maryland Residence (MM DD YYYY) FROM** _____ **TO** _____
Other state of residence: ____
If you began or ended legal residence in Maryland in 2020 place a **P** in the box. . . . . . . . . . . . . . . . . ▶ [ ]
**MILITARY:** If you or your spouse has **non-Maryland** military income, place an **M** in the box. . . . . . . ▶ [ ]
Enter **Military Income** amount here: _____

**EXEMPTIONS**

See Instruction 10. Check appropriate box(es). **NOTE:** If you are claiming dependents, you **must attach the Dependents' Information Form 502B** to this form to receive the applicable exemption amount.

A. ▶ [ ] **Yourself**   [ ] **Spouse** . . . . . Enter number checked [ ]   See Instruction 10   A. $ _____ . ___

B. ▶ [ ] 65 or over ▶ [ ] 65 or over

▶ [ ] Blind   ▶ [ ] Blind . . . . . . . Enter number checked [ ]   X $1,000 . . . . . . . . **B. $** _____ . ___

C. ▶ Enter number from line 3 of Dependent Form 502B . . . . . . . . [ ]   See Instruction 10   **C. $** _____ . ___

D. Enter Total Exemptions (Add A, B and C.) . . . . . . . . . . . . . ▶ [ ]   Total Amount. . . . **D. $** _____ . ___

COM/RAD-009

205020150

NAME _____     SSN _____

## MARYLAND HEALTH CARE COVERAGE

See Instruction 3.

Check here ▶ ☐  If you do not have health care coverage     DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐  If your spouse does not have health care coverage     DOB (mm/dd/yyyy) ▶ _____

Check here ▶ ☐  I authorize the Comptroller of Maryland to share information from this tax return with the Maryland Health Benefit Exchange for the purpose of determining pre-eligibility for no-cost or low-cost health care coverage.

E-mail address ▶ _____

## INCOME

See Instruction 11.

1. Adjusted gross income from your federal return . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 1. _____ . ___

1a. Wages, salaries and/or tips . . . . . . . . . . . . . . . . . . . ▶ 1a. _____ . ___

1b. Earned **income** . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 1b. _____ . ___

1c. Capital Gain or (loss) . . . . . . . . . . . . . . . . . . . . . . ▶ 1c. _____ . ___

1d. Taxable Pensions, IRAs, Annuities (**Attach Form 502R.**) ▶ 1d. _____ . ___

1e. **Place a "Y" in this box if the amount of your investment income is more than $3,650** . . . ▶ ☐

## ADDITIONS TO INCOME

See Instruction 12.

2. Tax-exempt interest on state and local obligations (bonds) other than Maryland . . . . . . . . ▶ 2. _____ . ___

3. State retirement pickup . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 3. _____ . ___

4. Lump sum distributions (from worksheet in Instruction 12.) . . . . . . . . . . . . . . . . . . . . ▶ 4. _____ . ___

5. Other additions (Enter code letter(s) from Instruction 12.)   ▶___ ___ ___ ___ . . . . ▶ 5. _____ . ___

6. Total additions to Maryland income (Add lines 2 through 5.) . . . . . . . . . . . . . . . . . . . . . ▶ 6. _____ . ___

7. Total federal adjusted gross income and Maryland additions (Add lines 1 and 6.) . . . . . . . . . . 7. _____ . ___

## SUBTRACTIONS FROM INCOME

See Instruction 13.

8. Taxable refunds, credits or offsets of state and local income taxes included in line 1 . . . . . ▶ 8. _____ . ___

9. Child and dependent care expenses . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 9. _____ . ___

10a. Pension exclusion from worksheet (13A) . . . . . . . **Yourself** ▶ ☐  **Spouse** ▶ ☐ . . ▶ 10a. _____ . ___

10b. Pension exclusion from worksheet (13E) . . . . . . . . **Yourself** ▶ ☐  **Spouse** ▶ ☐ . . ▶ 10b. _____ . ___

11. Taxable Social Security and RR benefits (Tier I, II and supplemental) included in line 1 . . . . ▶ **11.** _____ . ___

12. Income received during period of nonresidence (See Instruction 26.) . . . . . . . . . . . . . . ▶ 12. _____ . ___

13. Subtractions from attached Form 502SU . . . . . . . . . . . . . . ▶___ ___ ___ ___ . . . . ▶ 13. _____ . ___

14. Two-income subtraction from worksheet in Instruction 13 . . . . . . . . . . . . . . . . . . . . . ▶ 14. _____ . ___

15. Total subtractions from Maryland income (Add lines 8 through 14.) . . . . . . . . . . . . . . . ▶ 15. _____ . ___

16. Maryland adjusted gross income (Subtract line 15 from line 7.) . . . . . . . . . . . . . . . . . . . 16. _____ . ___

## DEDUCTION METHOD

See Instruction 16.

**All taxpayers must select one method and check the appropriate box.**

▶ ☐ **STANDARD DEDUCTION METHOD** (Enter amount on line 17.)

☐ **ITEMIZED DEDUCTION METHOD** (Complete lines 17a and 17b.)

17a. Total federal itemized deductions (from line 17, federal Schedule A) . ▶ 17a. _____ . ___

17b. State and local income taxes (See Instruction 14.) . . . . . . . . . . . . . ▶ 17b. _____ . ___

Subtract line 17b from line 17a and enter amount on line 17.

17. Deduction amount (Part-year residents see Instruction 26 (l and m).) . . . . . . . . . . . . . . . ▶ 17. _____ . ___

18. Net income (Subtract line 17 from line 16.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 18. _____ . ___

19. Exemption amount from Exemptions area (See Instruction 10.) . . . . . . . . . . . . . . . . . . . . 19. _____ . ___

20. Taxable net income (Subtract line 19 from line 18.) . . . . . . . . . . . . . . . . . . . . . . . . . . 20. _____ . ___

## MARYLAND TAX COMPUTATION

21. **Maryland tax** (from Tax Table or Computation Worksheet Schedules I or II) . . . . . . . . . . . 21. _____ . ___

22. Earned income credit (EIC)(See Instruction 18.) . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 22. _____ . ___

☐ Check this box if you are claiming the Maryland Earned Income Credit, but do not qualify for the federal Earned Income Credit.

23. Poverty level credit (See Instruction 18.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 23. _____ . ___

24. Other income tax credits for individuals from Part AA, line 13 of Form 502CR (**Attach Form 502CR.**) 24. _____ . ___

25. Business tax credits . . . . . . . . . **You must file this form electronically to claim business tax credits on Form 500CR.**

26. Total credits (Add lines 22 through 25.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 26. _____ . ___

27. Maryland tax after credits (Subtract line 26 from line 21.) If less than 0, enter 0. . . . . . . . . 27. _____ . ___

205020250

NAME _____ SSN _____

| | | |
|---|---|---|
| **LOCAL TAX COMPUTATION** | **28.** Local tax (See Instruction 19 for tax rates and worksheet.) **Multiply line 20 by your local tax rate** .0 _____ or use the Local Tax Worksheet . . . . . . . . . . . . . . . . . . . . 28. | _____ . ____ |
| | **29.** Local earned income credit (from Local Earned Income Credit Worksheet in Instruction 19.) . . 29. | _____ . ____ |
| | **30.** Local poverty level credit (from Local Poverty Level Credit Worksheet in Instruction 19.) . . . . 30. | _____ . ____ |
| | **31.** Local tax credit from Part BB, line 1 of Form 502CR (**Attach Form 502CR.**). . . . . . . . . . . . . 31. | _____ . ____ |
| | **32.** Total credits (Add lines 29 through 31.) . . . . . . . . . . . . . . . . . . . . . . . . . . . 32. | _____ . ____ |
| | **33.** **Local tax** after credits (Subtract line 32 from line 28.) If less than 0, enter 0 . . . . . . . . . . . 33. | _____ . ____ |
| | **34.** Total Maryland and local tax (Add lines 27 and 33.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . 34. | _____ . ____ |
| **CONTRIBUTIONS** See Instruction 20. | **35.** Contribution to Chesapeake Bay and Endangered Species Fund . . . . . . . . . . ▶ 35. _____ . ____ | |
| | **36.** Contribution to Developmental Disabilities Services and Support Fund . . . . . ▶ 36. _____ . ____ | |
| | **37.** Contribution to Maryland Cancer Fund. . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 37. _____ . ____ | |
| | **38.** Contribution to Fair Campaign Financing Fund . . . . . . . . . . . . . . . . . . . . . . . ▶ 38. _____ . ____ | |
| | **39.** **Total Maryland income tax, local income tax and contributions** (Add lines 34 through 38.) . 39. | _____ . ____ |
| | **40.** Total Maryland and local tax withheld (Enter total from your W-2 and 1099 forms and attach if MD tax is withheld.). . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 40. | _____ . ____ |
| | **41.** 2020 estimated tax payments, amount applied from 2019 return, payment made with an extension request, and **Form MW506NRS** . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 41. | _____ . ____ |
| | **42.** Refundable earned income credit (from worksheet in Instruction 21) . . . . . . . . . . . . . . . . ▶ 42. | _____ . ____ |
| | **43.** Refundable income tax credits from Part CC, line 8 of Form 502CR (**Attach Form 502CR. See Instruction 21.**) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 43. | _____ . ____ |
| | **44.** Total payments and credits (Add lines 40 through 43.) . . . . . . . . . . . . . . . . . . . . . . . . . . . 44. | _____ . ____ |
| | **45.** Balance due (If line 39 is more than line 44, subtract line 44 from line 39. See Instruction 22.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 45. | _____ . ____ |
| | **46.** Overpayment (If line 39 is less than line 44, subtract line 39 from line 44.). . . . . . . . . . . ▶ 46. | _____ . ____ |
| **REFUND** | **47.** **Amount of overpayment TO BE APPLIED TO 2020 ESTIMATED TAX**. . . . . . . . . . . . . ▶ 47. | _____ . ____ |
| | **48.** Amount of overpayment **TO BE REFUNDED TO YOU** (Subtract line 47 from line 46.) See line 51 . . . . . . . . . . . . . . . . . . . . . . . . . . **REFUND** ▶ 48. | _____ . ____ |
| | **49.** Check here ☐ if you are attaching Form 502UP. Enter interest charges from line 18 of Form 502UP _____ or for late filing _____ . . . . . . . . . . . . . . . . . . . . . . ▶ 49. | _____ . ____ |
| **AMOUNT DUE** | **50.** **TOTAL AMOUNT DUE** (Add lines 45 and 49.) **IF $1 OR MORE, PAY IN FULL WITH THIS RETURN.  INCLUDE FORM PV.** . . . . . . . . . . 50. | _____ . ____ |

205020350

NAME _____ SSN _____

**DIRECT DEPOSIT OF REFUND** (See Instruction 22.) Be sure the account information is correct. **For Splitting Direct Deposit**, use Form 588. To comply with banking and **NACHA (National Automated Clearing House Association)** rules, if this refund will go to an account outside of the United States, place "Y" in this box ▶ ☐   or if you authorize the State of Maryland to direct deposit your refund, check this box ▶ ☐   and complete the following information clearly and legibly.

**51a.** Type of account: ▶ ☐ Checking  ☐ Savings   **51b.** Routing Number (9-digits) ▶ _____

**51c.** Account Number ▶ _____

**51d.** Name(s) as it appears on the bank account _____

▶ _____  _____            ▶ _____ _____ _____
   Daytime telephone no.       Home telephone no.                CODE NUMBERS (3 digits per line)

Check here ☐ if you authorize your preparer to discuss this return with us.  Check here ▶ ☐ if you authorize your paid preparer not to file electronically. Check here ▶ ☐ if you agree to receive your 1099G Income Tax Refund statement electronically (See Instruction 24.)

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements and to the best of my knowledge and belief it is true, correct and complete. If prepared by a person other than taxpayer, the declaration is based on all information of which the preparer has any knowledge.

_____ _____        _____ _____
Your signature             Date            Spouse's signature          Date

_____                 _____
Printed name of the Preparer / or Firm's name    Street address of preparer or Firm's address

_____                 _____
Signature of preparer other than taxpayer **(Required by Law)**    City, State, ZIP Code + 4

                                          _____  ▶ _____
                                          Telephone number of preparer    Preparer's PTIN **(Required by Law)**

**For returns filed without payments, mail your completed return to:**

Comptroller of Maryland
Revenue Administration Division
110 Carroll Street
Annapolis, MD 21411-0001

**For returns filed with payments, attach check or money order to Form PV. Make checks payable to Comptroller of Maryland. Do not attach Form PV or check/money order to Form 502.  Place Form PV with attached check/money order on TOP of Form 502 and mail to:**

Comptroller of Maryland
Payment Processing
PO Box 8888
Annapolis, MD 21401-8888

**MARYLAND FORM 502B**

**Dependents' Information**
(Attach to Form 502, 505 or 515.)

20502B050

**2020**

Print Using Blue or Black Ink Only

▶ _____ Your Social Security Number

▶ _____ Spouse's Social Security Number

_____ ___ Your First Name                MI

_____ Your Last Name

_____ ___ Spouse's First Name             MI

_____ Spouse's Last Name

**Summary**

1. Enter the total number checked below for Regular dependents ( . . . . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 1. _____
2. Enter the total number checked below for dependents 65 or over ( . . . . . . . . . . . . . . . . . . . . . . . . . ▶ 2. _____
3. Total dependent exemptions (Add lines 1 and 2 and enter the total here and on line (C) of t
   Exemptions area of Form 502, 505 or 515.) . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . . 3. _____

**Dependents** (If a dependent listed below is age 65 or over, check both 4 and 5.)

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI __ ▶ Last Name _____

Social Security Number          Relationship                          Regular    65 or over

▶ 2. _____   3. _____   4. __   5. __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

**MARYLAND FORM**
**502B**

**Dependents' Information**
(Attach to Form 502, 505 or 515.)

20502B150

NAME _____ SSN _____

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

---

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

---

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

---

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

---

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

---

▶ 1.
First Name _____ MI __ ▶ Last Name _____

▶ 2.
Social Security Number _____ 3. Relationship _____ 4. Regular __ 5. 65 or over __

Check here ▶ ☐ if this dependent does not have health care coverage

DOB (MM/DD/YYYY) ▶ _____

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