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# 9999

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 24 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 $28,327?

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 24 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 24 of your D-40. If you answered yes to question 5 or 6, you must also complete Part III.

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

Enter your lastname XXXXXXXXXXXXXXXXXXX

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 Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	X	XX
8	First name and M.I. XXXXXXXXXXXX X Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	X	XX
9	First name and M.I. XXXXXXXXXXXX X Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	X	XX
10	First name and M.I. XXXXXXXXXXXX X Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	X	XX
11	First name and M.I. XXXXXXXXXXXX X Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999999999	X	XX
12	First name and M.I. XXXXXXXXXXXX X Last name XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	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 24.....	17	9999999.00