Gover	nment of the
Distric	of Columbia

2022 Schedule HSR SUB DC Health Care Shared Responsibility



Unless Instructed otherwise- if you fill

any part of this schedule, attach it to your D-40

SOFTWARE DEVELOPER USE ONLY VENDOR ID# 99

Personal information

XXXXXXXXXXXXXXX

XXXXXXXXXXXXXXX

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)

99999999

99999999

Last name

999999999

99999999

Your first name M.I. Last name

Spouse's/registered domestic partner's first name M.I.

X XXXXXXXXXXXXXXXXXXXXXX

Mailing address (number, street and suite/apartment number if applicable)

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Zip Code +4

999999999

## PART I Do you have qualifying health coverage?

- Did you and, if applicable, all members of your health care shared responsibility family, have qualifying health coverage for every month in 2022?
  - X Yes. STOP. You do not owe a health care shared responsibility payment and do not need to complete a Schedule HSR. (Enter zero on Line 25 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 2022?
  - X Yes. Proceed to Part IV. See instructions.
  - X No.
- 3 Was your federal adjusted gross income below the applicable filing threshold for your filing status for 2022? See instructions.
  - X Yes. Proceed to Part IV. See instructions.
  - X No.
- Was your federal adjusted gross income, reported on your D-40, Line 4 for 2022, equal to or less than 30,033.90?
  - X Yes. Proceed to Part IV. See instructions.
  - X No.

If you answered Yes to any of questions 2 - 4, enter zero on Line 25 of your D-40. If not, continue by answering questions 5 - 6.

- 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 2022 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.
- Are you claiming an exemption (other than a sincerely held religious belief) for at least one month for 2022 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 25 of your D-40. If you answered yes to question 5 or 6, you must also complete Part III.

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77



## PART III What coverage exemptions are you claiming for members of your shared responsibility family and for how many months? See instructions for exemption type(s).

Name	of Individual	Taxpayer Identification Number (TIN)	Exemption Type	Number of Exempt Months Claimed
First name and M.I.				Olalinica
XXXXXXXXXX	X			
7		999999999	X	XX
Last name				
XXXXXXXXXXX	XXXXXXXXXXXXXXXXXXX	XXX		
First name and M.I.				
XXXXXXXXXXX	X	00000000	7.7	
8		99999999	X	XX
Last name	XXXXXXXXXXXXXXXXX	YYY		
First name and M.I.	X			
9	22	99999999	X	XX
Last name				
	XXXXXXXXXXXXXXXXX	XXX		
First name and M.I.				
XXXXXXXXXX	X			
10		99999999	X	XX
Last name				
	<u> </u>	XXX		
First name and M.I.	77			
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	X	99999999	X	XX
				ΔΔ
Last name XXXXXXXXXXXX	xxxxxxxxxxxxxxxx	XXX		
First name and M.I.				
XXXXXXXXXXXX	X			
12		999999999	X	XX
Last name				
	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	<del></del>		
PART IV Complet	e the applicable workshe	ets before completing Part IV.	Round cents to ne If amount is zero, le	
13 Enter flat dollar amount (see Worksheet A-1, Line 5 or Worksheet A-2, Line 7)				
13 Enter flat dollar amo	ount (see Worksheet A-1, Line 5 or	Worksheet A-2, Line 7)	13 999999	9.00
1 A Futou H		1 Line 4 or Mortobert D.O. Line 143	14 999999	0 00
14 Enter the percentage	e income amount (see worksneet B	-1, Line 4 or Worksheet B-2, Line 14)	14 999999	9.00
15 Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the same, enter that number.)		15 999999	9 00	
10 Liliei tile laigei Ui L	ino 19 of Line 14 (il Lines 19 and	17 are the same, enter that number./		
16 Enter the District Av	verage Bronze Plan Premium (see W	Vorksheet C-1, Line 2 or Worksheet C-2,		
Line 2)	)		16 999999	9.00
17 Enter the smaller of	Line 15 or Line 16 here and on D-	40, Line 25	17 999999	9.00