# STATE OF HAWAII DEPARTMENT OF TAXATION



# General Information and Scannable Specifications for Schedule X (Rev. 2018)

#### **Contact Information for General Questions**

Hawaii Department of Taxation Technical Section Attn: Sharlene Tagami, Forms Coordinator 830 Punchbowl Street, Rm 126 Honolulu, Hawaii 96813

> Telephone: (808) 587-1577 Fax: (808) 587-1584

E-mail: Tax.Technical.Section@hawaii.gov

# Contact Information for Mailing Test Packages and Testing Inquiries

Hawaii Department of Taxation Attn: Document Processing — Quality Assurance Test Team 830 Punchbowl Street, Rm 126 Honolulu, Hawaii 96813

Email: tax.dp.qa@hawaii.gov

**lote:** Reproduced forms must meet the requirements as established in this document and our current Forms Reproduction Policy.

## Schedule X (Rev. 2018)

General Information and Scannable Specifications

This document provides software vendors with the requirements for reproducing Schedule X. Schedule X is designed for electronic scanning that permits faster processing with fewer errors. Software developers who reproduce, develop, or distribute Schedule X must create the form so the variable data (specified fields containing taxpayer information) are printed in a fixed format that can

be read by the Department's IBML scanners. A 2D QR code must be present on each page of the form.

Substitute scannable forms MUST meet the requirements as established in this document and our current Forms Reproduction Policy, and be approved prior to release or distribution.

#### **GENERAL INFORMATION**

#### 1. Substitute Form

- We highly recommend you use the Department's official Schedule X PDF.
- If you do not use the Department's official PDF, the substitute form must match the Department's form in layout and appearance including **bold** and/or *italics* fonts as they appear on the official form.
- Lines of text in a paragraph must break at the same location as the official form.
- All forms and variable data must have a high standard of legibility for printing.
- Photocopies of the scannable form must not be submitted to the Department for processing.
- Substitute scannable forms must be proofread prior to submission.

#### 2. Paper and Ink

- The paper size is 8.5 inches by 11 inches, the same size as the Department's original form. The paper weight must be at least 20 pound white bond and the page orientation is portrait.
- Black ink should be used in printing the text on the form and the variable data.

#### 3. Fonts

- The form was designed using the following font:
  - 1. Helvetica
- The following fonts and sizes should be used for the form number and revision year located at the top left corner on page 1 of the form:
  - 1. Schedule X: 12 pt Helvetica bold
  - 2. Form N-11/N-15: 8 pt Helvetica narrow
  - 3. Rev. 2018: 8 pt Helvetica bold
- The following fonts and sizes should be used for the form number and revision year located at the top left corner on page 2 of the form:
  - Schedule X (Form N-11/N-15)(Rev. 2018): 8 pt Helvetica (Schedule X is bold)

- The following font and size should be used for the form number located at the bottom right corner on page 1 of the form:
  - 1. Schedule X: 8 pt Helvetica bold

#### 4. Variable Data

- All variable data fields must utilize 10 pt Courier font.
- All variable data fields require exact placement.
- · Print all alpha characters uppercase.

#### 5. Variable Data Delimiters

 Taxpayer's Social Security Number must be printed with spaces between the dash (-) delimiters. For example:

123 - 45 - 6789

(3 digits, followed by a space, followed by a dash (-), followed by a space, followed by 2 digits, followed by a space, followed by a dash (-), followed by a space, followed by 4 digits)

#### 6. Dollar Amounts

99999999

- Do not use commas as thousand separators.
- · Do not use leading dollar signs.
- · Amounts are right justified.
- Amounts must be rounded. Dollar and cent signs should not be used when the field is rounded to whole dollars.

#### 7. Testing and Approval of the Scannable Form

- A minimum of 5 hardcopy test samples must be provided to ensure proper testing including 1 hardcopy test sample that contains all maximized fields (one alpha "X" or numeric "9" character space with no leading or tailing spaces).
- Test samples must be originals. Photocopies, fax submissions, etc. will not be accepted.
- Test samples must be populated with unique sample variable data showing different scenarios.

- It will require 1 to 2 weeks, upon receipt by the Department, to verify the accuracy of the submitted sample.
- Approval of the facsimile must be obtained from the Department prior to filing.
- Schedule X (Rev. 2018) cannot be filed until 2019.

#### SCANNABLE SPECIFICATIONS

#### 1. Layout

 Open space around variable data fields should be adhered to as much as possible except for the areas that do not require optical character recognition. Do not place any additional information in these areas.

#### 2. Hawaii Vendor I.D. Number

- Print your 2-digit Hawaii Vendor I.D. Number following the "ID NO" label at the following position:
  - 1. Pages 1-2: The 2-digit Hawaii Vendor I.D. Number should begin at column 42, row 65.

#### 3. QR code

- A QR code is specific to the form. The property of the 2D symbology QR code is measured in CM.
- Placement of the QR code is as follows (see exhibit for exact placement):
  - 1. Page 1: The left bottom corner of the QR code is at the beginning of column 6 and at the bottom of row 10.
  - Page 2: The left bottom corner of the QR code is at the beginning of column 6 and at the bottom of row 8.
- · Height of the QR code is 0.5 inch.
- Length of the QR code is 0.5 inch.
- Narrow Module Size is set to 0.18.
- Margin is set to 0.18.
- Open space surrounding the QR code should be adhered to as much as possible.
- DO NOT stretch the QR code image.

 The required QR code for page 1 is: SCHX\_T 2018A 01 VIDXX

The required QR code for page 2 is: SCHX\_T 2018A 02 VIDXX

The QR code includes the form number (SCHX), an underscore, type of form (T), space, 4-digit form year (2018), 1-letter revision indicator (A), space, 2-digit page number (01) or (02), space, vendor I.D. label (VID), and your 2-digit Hawaii Vendor I.D. Number (XX). There are no hyphens.

- The human readable text for the QR code must be printed at the bottom of each page at column 6, row 64, utilizing 6pt Helvetica font.
- Please do not print the outline around the human readable text and QR code. These were only used to show the placement of the human readable text and QR code.
- DO NOT use Windows Metafile Format (wmf).
   This format causes a very low read rate by the Department's IBML scanners.

#### 4. Acetate Overlays

- Acetate overlays will assist in the exact data field placement. Verify your form samples with the overlays prior to submitting them for testing. If the samples do not match the overlays within 1/16 inch, do not submit them for approval as they will be rejected.
- Acetate overlays will be mailed to vendors who submitted a Letter of Intent to participate in the Forms Reproduction Program and who will be reproducing Schedule X. If you did not receive the acetate overlays, please contact the Forms Coordinator.

#### 10 12 SCHEDULE X

(FORM N-11/N-15)

#### STATE OF HAWAII -- DEPARTMENT OF TAXATION

 52 54

 

### TAX CREDITS FOR HAWAII RESIDENTS

(REV. 2018)

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QR Code	Caution:	Before con	nnletina	Schedul	e X' n	lease	read	the I	netruc	tior

ns on pages 33 - 36 Here of the Form N-11 booklet, or pages 37 - 40 of the Form N-15 booklet.

Name(s) as shown on Form N-11 or N-15	Tour Social Security number
NAMES AS SHOWN ON TAX RETURN XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	999-99-9999
PART I: CREDIT FOR LOW-INCOME HOUSEHOLD RENTERS	

- 1 Is your adjusted gross income (Form N-11, line 20; or Form N-15, line 35, Column A) less than \$30,000? If "No," STOP. You cannot claim this credit. If "Yes," go to Question 2.
- 2 Are you a resident who was present in Hawaii more than nine months of the taxable year? If "No," STOP. You cannot claim this credit. If "Yes," go to Question 3.
- 3 Can you be claimed as a dependent by another taxpayer? If "Yes," STOP. You cannot claim this credit. If "No," go to line 4.
- 4 Eriter required information for each rental unit that was fully subject to real property tax. Do not list rental units that were wholly or partially exempt from real property tax. If you occupied more than one qualified unit, submit the required information for each additional unit on a separate sheet. If you shared the unit with others, eriter only your share of the rent

month month

(Hawaii Tax I.D. No.) name

- 5 Add up your share of rent paid during the taxable year for all the units you have listed... 9999999999.00
- 99999999999.00 6 Enter the amount of your exclusions (e.g., utilities, parking stalls, ground rent, rental subsidies such as public assistance)..... 9999999999.00
- 8 List YOURSELF, YOUR SPOUSE, AND YOUR DEPENDENTS that meet all of the following: a) Resident of Hawaii, b) Present in Hawaii for more than nine months in 2018, and c) Cannot be claimed as a dependent by another taxpayer. include minor children receiving more than half of their support from public agencies which you can claim as dependents.

1	3	Name	Relationship	Name	Relationship
Ŧ,		NAME 1 XXXXXXXXXXXXXXXXXXXXXXXXXXX	Self	NAME 4: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	RSHIP 2
+		NAME 2 XXXXXXXXXXXXXXXXXXXXXXXXXXX	Spouse	NAME 5 XXXXXXXXXXXXXXXXXXXXXXXXXXXX	RSHIP 3
t		NAME 3 XXXXXXXXXXXXXXXXXXXXXXXXXXX	RSHIP 1	NAME 6 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	RSHIP 4
					0.0

Enter the number of qualified persons listed above. 9 If you are a qualified exemption and you are age 65 or over, enter 1. Otherwise, enter -0-...... 

10 If you are married filing jointly or married filing separately where your spouse is not filing a Hawaii return, had no income, and was not the dependent of someone else; and your spouse is a qualified exemption; and your spouse is age 65 or over; enter 1. Otherwise, enter -0-...... 

12 Multiply the number of exemptions on line 11 by \$50 and enter the result here and on Form N-11, line 29; or Form N-15, line 46. This is your credit for low-income household renters. (Whole dollars only)....... 

#### PART II: CREDIT FOR CHILD AND DEPENDENT CARE EXPENSES

#### Section A: Care Provider Information

Complete line 1 columns (a) through (e) for each person or organization that provided the care. If you do not give the information asked for in each column, or if the information you give is not correct, your credit and, if applicable, the exclusion of employer-provided dependent care benefits may be disallowed.

4/					
48 1	(a) Care		(c) Identification number	(d) Hawaii Tax	(e) Arnount paid
49	provider's name	(number, street, city, state, and Postal/ZiP code)	(\$SN or FEIN)	i.D. No.	
CARE	PROVIDER XX			000 000 0000 00	
5CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXXX	9999999999999	GE 999 - 999 - 99	999999999.00
5CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXX		000 000 0000 00	
CARE,	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXX	9999999999999	GE 999 - 999 - 99	999999999.00

Section B: Dependent Care Benefits - (If you did not receive dependent care benefits, skip to line 21)

- 2 Enter the total amount of dependent care benefits you received in 2018. Amounts you received as an employee should be shown in Box 10 of your federal Form(s) W-2. If you were self-employed or a partner, include amounts you received under a dependent care assistance program from your sole proprietorship or partnership............
- 3 Enter the amount, if any, you carried over from 2017 and used in 2018 during the grace period......
- 4 Enter the amount, if any, you forfeited or carried forward to 2019. (See the Instructions)

28 30 

5 Combine lines 2 through 4......

Human Readable text here 16

999999999.00 999999999.00

(9999999999,00)

999999999.00 

18 20

 48 50 52 54

2											2
3	4	6		56 58 60 62	64 66	68	70 72	74	76 78	80	82 8
4		SCF	HEDULE X (FORM N-11/N-15) (REV. 2018)						PAG	iE 2	4
5			Name(s) as shown on Form N-11 or N-15		T Yo	our so	ocial se	curity r	umbe	r	5
6			Place NAMES AS SHOWN ON TAX RETURN XXXXXXXXXXXXXXXXXXXXX	CXXXXXXXX	999		_ 999	1			6
7			R Code		1						7
8		ŀ	Here								8
9											9
1	0	6	Enter the total amount of qualified expenses incurred in 2018 for the care of the qualifying person(s) 6 99	999999999	9.00						10
1	1	7	Enter the smaller of line 5 or 6	999999999	9.00						11
1	2	8	Enter your earned income. (See the Instructions)	999999999	00.						12
1	3	9	If married filing jointly, enter your spouse's earned income (if you or your spouse								13
1	4		was a student or disabled, see the Instructions); if married filing separately,								14
1	5		see the mist details, an others, enter the difficult from the commission of the comm	999999999	9.00						15
1	6	10	Enter the smallest of line 7, 8, or 9	999999999	00.6						16
1	7		3-1								17
1	8		spouse's earned income on line 9)	999999999	9.00						18
1	9	12	Is any amount on line 2 from your sole proprietorship or partnership?								19
2	0.		No. Enter -0								20
2			Yes. Enter the amount here			12	9999	9999	99.	00	21
2	-			99999999							22
2	.3		Deductible benefits. Enter the smallest of line 10, 11, or 12. Also, include this amount on the app	ropriate line(s	) of						23
2			your return			14	9999	9999	99.	00	24
2	.5	15	Excluded benefits. If line 12 is zero, enter the smaller of line 10 or 11. Otherwise, subtract line 14	from the sma	ller of						25
2	6		line 10 or 11. If zero or less, enter -0			15	9999	9999	99.	00	26
2	.7	16	Taxable benefits. Line 13 minus line 15. If zero or less, enter -0 Also, include this amount on For				2000	0000	.00	00	27
2	.8		On the dotted line next to line 7, write "DCB." (Form N-11 filers, see the Instructions)			16		9999			28
2			Enter \$2,400 (\$4,800 if two or more qualifying persons)			17	9999				29
3		-	Add lines 14 and 15			18	9999	9999	99.	00	30
3	1	19	Line 17 minus line 18. If zero or less, \$TOP. You cannot take the credit. Exception. If you paid 2	2017 expenses	sin		2000	0000		00	31
	2		2018, see the Instructions for line 28			19	9999	9995	199.	00	32
3	3	20	Complete line 21. Do not include in column (d) any benefits shown on line 18. Then, add the amou	ints in column	(d)	20	9990	9999	000	0.0	33
			and enter the total here.					コココヤヤ	' -   -		
3		Sac		uet file a joint	return to		n tha ta	v crad	+ )		34
3	5	Sec	ction C: Credit for Child and Dependent Care Expenses — (If you are married, you m	ust file a joint	return to					ses	35
3	6	Sec 21	ction C: Credit for Child and Dependent Care Expenses — (If you are married, you m	Qualifying pers	on's soc	clain	(d) Qu	alified e curred	expens and pa	aid	35 36
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#### **SCHEDULE X**

(FORM N-11/N-15) (REV. 2018)

# STATE OF HAWAII — DEPARTMENT OF TAXATION TAX CREDITS FOR HAWAII RESIDENTS

2018

Both pages of Schedule X **must** be attached to Form N-11 or N-15

Place QR Code Here

Caution: Before completing Schedule X, please read the Instructions on pages 33 - 36 of the Form N-11 booklet, or pages 37 - 40 of the Form N-15 booklet.

Name(s) as shown on Form N-11 or N-15 Your social security number NAMES AS SHOWN ON TAX RETURN XXXXXXXXXXXXXXXXXXXXXXXXXX 999-99-9999 PART I: CREDIT FOR LOW-INCOME HOUSEHOLD RENTERS 1 Is your adjusted gross income (Form N-11, line 20; or Form N-15, line 35, Column A) less than \$30,000? If "No," STOP. You cannot claim this credit. If "Yes," go to Question 2. 2 Are you a resident who was present in Hawaii more than nine months of the taxable year? If "No," STOP. You cannot claim this credit. If "Yes," go to Question 3. 3 Can you be claimed as a dependent by another taxpayer? If "Yes," STOP. You cannot claim this credit. If "No," go to line 4. 4 Enter required information for each rental unit that was fully subject to real property tax. Do not list rental units that were wholly or partially exempt from real property tax. If you occupied more than one qualified unit, submit the required information for each additional unit on a separate sheet. If you shared the unit with others, enter only your share of the rent Occupied From MONTH XXXXXXXXXXX, 2018, To MONTH XXXXXXXXXXX, 2018. Total rent paid for this period. \$ 999999999 month month Owned by (or agent for owner) NAME AND ADDRESS OF OWNER XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX GE 999 - 999 - 999 - 999 (Hawaii Tax I.D. No.) address 5 Add up your share of rent paid during the taxable year for all the units you have listed...... 5 9999999999.00 6 Enter the amount of your exclusions (e.g., utilities, parking stalls, ground rent, rental subsidies such as public assistance)...... 6 9999999999.00 9999999999.00 8 List YOURSELF, YOUR SPOUSE, AND YOUR DEPENDENTS that meet all of the following: a) Resident of Hawaii, b) Present in Hawaii for more than nine months in 2018, and c) Cannot be claimed as a dependent by another taxpayer. Include minor children receiving more than half of their support from public agencies which you can claim as dependents.

8	Name Relationship Name			F	Relationship		
	NAME 1 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX					RSHIP 2	
	NAME 2 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			XF	RSHIP 3		
	NAME 3 XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX					RSHIP 4	
	Enter the number of qualified persons listed above.						
9	9 If you are a qualified exemption and you are age 65 or over, enter 1. Otherwise, enter -0						
10	If you are married filing jointly or married filing separately wher	e your spouse	is r	not filing a Hawaii			
	return, had no income, and was not the dependent of someon	e else; and you	ır s	pouse is a qualified			
	exemption; and your spouse is age 65 or over; enter 1. Otherw	ise, enter -0			10	99	
11	11 Add lines 8 through 10						
12	Multiply the number of exemptions on line 11 by \$50 and en	er the result h	ere	and on Form N-11, line 29;			
	or Form N-15, line 46. This is your credit for low-income household renters. (Whole dollars only)						

#### PART II: CREDIT FOR CHILD AND DEPENDENT CARE EXPENSES

#### Section A: Care Provider Information

Complete line 1 columns (a) through (e) for each person or organization that provided the care. If you do not give the information asked for in each column, or if the information you give is not correct, your credit and, if applicable, the exclusion of employer-provided dependent care benefits may be disallowed.

1	(a) Care	(b) Address	(c) Identification number	(d) Hawaii Tax	(e) Amount paid	
	provider's name	vider's name (number, street, city, state, and Postal/ZIP code)		I.D. No.		
CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXXX		000 000 000	0000	
CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXXXX	9999999999999	GE 9 9 9 - 9 9 9 - 9 9 9		999999999.00
CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXXX		000 000 000	00 00	
CARE	PROVIDER XX	ADDRESS XXXXXXXXXXXXXXXXXXXX	9999999999999	GE 999 - 999 - 9999 - 99		999999999.00
Sec						
2	Enter the total amoun					

Section B: Dependent Care Benefits — (If you did not receive dependent care benefits, skip to line 21)

2 Enter the total amount of dependent care benefits you received in 2018. Amounts you received as an employee should be shown in Box 10 of your federal Form(s) W-2. If you were self-employed or a partner, include amounts you received under a dependent care assistance program from your sole proprietorship or partnership.

3 Enter the amount, if any, you carried over from 2017 and used in 2018 during the grace period.

4 Enter the amount, if any, you forfeited or carried forward to 2019. (See the Instructions).

5 Oombine lines 2 through 4.

Place QR Code Here 

6	Enter the total amount of qualified expenses incurred in 2018 for t	he care of the qualify	ing person(s	s)	6	999999999.00			
7	7 Enter the smaller of line 5 or 6				7	999999999.00			
8	B Enter your earned income. (See the Instructions)				8	999999999.00			
	If married filing jointly, enter your spouse's earned inco								
	was a student or disabled, see the Instructions); if mai								
	see the Instructions; all others, enter the amount from		-		9	999999999.00			
10	Enter the smallest of line 7, 8, or 9.				10	999999999.00			
	Enter \$5,000 (\$2,500 if married filing separately and y								
• •	spouse's earned income on line 9)				11	999999999.00			
12	2 Is any amount on line 2 from your sole proprietorship								
	No. Enter -0	or partificially:							
	Yes. Enter the amount here						12	9999999999	9 00
12	3 Line 5 minus line 12						12		7.00
	Deductible benefits. Enter the smallest of line 10, 11								
14							4.4	9999999999	9 00
	your return						14	333333333	9.00
15	5 Excluded benefits. If line 12 is zero, enter the smalle						l	000000000	0 00
	line 10 or 11. If zero or less, enter -0						15	9999999999	9.00
16	Taxable benefits. Line 13 minus line 15. If zero or les					·		000000000	0 00
	On the dotted line next to line 7, write "DCB." (Form N						16	9999999999	
	7 Enter \$2,400 (\$4,800 if two or more qualifying persons						17	9999999999	9.00
	Add lines 14 and 15						18	9999999999	9.00
19	Deline 17 minus line 18. If zero or less, STOP. You can		_		-				
	2018, see the Instructions for line 28						19	9999999999	9.00
20	O Complete line 21. Do not include in column (d) any be								
	and enter the total here						20	9999999999	9.00
Se	ection C: Credit for Child and Dependent Car	e Expenses –	- (If you ar	e marri	ed, y	ou must file a joint return to	o clain		
21	(a) Qualifying person's name		(b) Rela	tionshi	р	(c) Qualifying person's so security number	cial	(d) Qualified exp you incurred and in 2018 for the p listed in colum	d paid erson
Q	QUALIFYING PERSON NAME XXXXXXXXXX	xxxxxxxx	RSHIP	XXXX	XX	999-99-9999		999999999	9.00
Q	QUALIFYING PERSON NAME XXXXXXXXXX	XXXXXXXXX	RSHIP	XXXX	XX	999-99-9999		999999999	9.00
22	2 Add the amounts in column (d) of line 21. Do not ente	r more than \$2,40	00 for one	qualify	ing pe	erson or \$4,800 for two			
	or more persons. If you completed Section B, enter the si	maller of line 19 or	20				22	999999999	9.00
23	B Enter your earned income. (See the Instructions)						23	999999999	9.00
24	If married filing jointly, enter your spouse's earned inco	ome (if you or you	ır spouse	was a s	stude	nt or disabled,			
	see the Instructions); all others, enter the amount from	n line 23					24	999999999	9.00
25	Enter the smallest of line 22, 23, or 24						25	999999999	9.00
26	Enter your adjusted gross income from Form N-11, lin	e 20; or Form N-	15, line 35	,					
	Column A				26	999999999.00			
27	7 Enter on line 27 the decimal amount shown below tha	t applies to the ar	mount on I	ine 26.					
	If line 26 is: Decimal amount is: If line 2		cimal amo						
		1 – 45,000	.21	unt is.	Ŀ				
		1 – 50,000	.20						
		1 and over	.15						
	\$35,001 – 40,000 .22						27	×	0.99
28	Multiply line 25 by the decimal amount on line 27. If yo	ou paid 2017 expe	enses in 2	018. se	e the	Instructions.			
	Enter the result here and on Form N-11, line 30; or Fo								
	dependent care expenses. (Whole dollars only)		-				28	999999999	00