

2025 Tax Organizer Personal Information

Personal Information

Name		SSN	Has IP PIN	Date of Birth
Taxpayer				
Spouse				
Name of person to whom all information should be addressed, if not the taxpayer				
Street address, city, state, and ZIP				
Occupation		Daytime Phone	Evening Phone	Cell Phone
Taxpayer				
Spouse				
Taxpayer email				
Spouse email				

Filing status at the end of 2025

- ☐ Single ☐ Married ☐ Widowed - If widowed and your spouse died after December 31, 2023, enter the date of death _____
- ☐ Married filing separately - If married but filing separately, did you live apart from your spouse for the last six months of 2025? _____

Yes No

- ☐ ☐ Are you or your spouse blind?
- ☐ ☐ Are you or your spouse disabled?
- ☐ ☐ Are you or your spouse a full-time student?
- ☐ ☐ Do you or your spouse want to designate \$3 to go to the Presidential Election Campaign Fund?
- ☐ ☐ At any time during 2025 did you:
- (a) receive (as a reward, award, or payment for property or service) a digital asset?
- (b) sell, exchange, gift, or otherwise dispose of a digital asset (or a financial interest in a digital asset)?

Identification Information

Taxpayer's type of photo ID

- ☐ Driver's license ☐ State-issued photo ID

Photo ID number _____

State photo ID was issued _____

Date photo ID was issued _____

Date photo ID expires _____

Spouse's type of photo ID

- ☐ Driver's license ☐ State-issued photo ID

Photo ID number _____

State photo ID was issued _____

Date photo ID was issued _____

Date photo ID expires _____

Account Information for Deposits and Withdrawals

Name of Bank	Bank Routing Number	Bank Account Number	Type of Account		Use this Account for	
			Checking	Savings	Deposits	Withdrawals

Appointment Information

Your 2025 appointment is scheduled for _____

Dependent and Other Information

Name:

SSN:

Dependent Information

First and Last Name SSN	Has IP PIN	Relationship	Months in Home	Date of Birth	Disabled	Full- time Student	Childcare Expenses

List dependents required to file a return

Child and Other Dependent Care Expenses

Name of Care Provider	Address	SSN or EIN	Amount Paid

Estimates

	Federal		Resident State		Resident City	
	Date Paid	Amount	Date Paid	Amount	Date Paid	Amount
Overpayment applied from 2024						
First quarter						
Second quarter						
Third quarter						
Fourth quarter						
Additional payments						

Schedule A - Itemized Deductions

Name: _____

SSN: _____

Medical and Dental Expenses

Health insurance premiums
(paid by you, not through work) _____

Amount above that is for Medicare premiums _____

Long-term care premiums (you) _____

Long-term care premiums (your spouse) _____

Long-term care premiums (dependents) _____

Mileage driven for medical purposes _____

Out of pocket medical & dental expenses

Doctor, dental, etc _____

Prescription medicines _____

Glasses & contacts _____

Hearing aids _____

Medical equipment & supplies _____

Hospital services _____

Laboratory services _____

Nursing services _____

Other _____

Other _____

Taxes Paid

State and local income taxes _____

General sales tax (vehicle, boat, home, etc.) _____

Real estate taxes _____

Personal property taxes _____

Auto registration taxes not
deductible for state _____

Other taxes (list) _____

Interest Paid

Home mortgage interest paid (attach Form 1098) _____

☐ Some of your home mortgage loan was not
used to buy, build, or improve your home.

Home mortgage interest paid to an individual _____

Paid to:

Name _____

Address _____

City, State, ZIP _____

SSN or EIN _____

Points not reported on Form 1098 _____

Investment interest _____

Charitable Contributions

Donations to charity	Cash	Noncash	Amount
Church	<input type="checkbox"/>	<input type="checkbox"/>	_____
Boy or Girl Scouts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Goodwill	<input type="checkbox"/>	<input type="checkbox"/>	_____
Red Cross	<input type="checkbox"/>	<input type="checkbox"/>	_____
Salvation Army	<input type="checkbox"/>	<input type="checkbox"/>	_____
United Way	<input type="checkbox"/>	<input type="checkbox"/>	_____
Veterans	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hospital	<input type="checkbox"/>	<input type="checkbox"/>	_____
University	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____
Miles driven for charitable purposes			_____

Other Miscellaneous Deductions

Amortizable bond premiums _____

Federal estate tax _____

Gambling losses _____

Impairment-related work expenses _____

Claim repayments _____

Unrecovered pension investments _____

Loss from other activities from Schedule K-1 _____

Ordinary loss debt instrument _____

Excess deduction on termination _____

Job Expenses & Certain Miscellaneous Deductions

Necessary job expenses you paid that were not reimbursed by your employer

Safety equipment, tools, & supplies _____

Uniforms _____

Protective clothing (shoes, hardhats, glasses, etc.) _____

Dues to professional organizations _____

Books & subscriptions _____

Other _____

Union dues _____

Tax preparation fees _____

Other nonpersonal expenses related to taxable income

Safe deposit box fees _____

Investment expenses not entered elsewhere _____

Other _____

Home equity interest _____

Healthcare Coverage Questionnaire

Name:

SSN:

Healthcare Information

Member of Household for Healthcare Purposes	Covered the Entire Year	Covered Less than 12 Months	No Healthcare Coverage at All

YES NO

☐ ☐ Did anyone other than you or your spouse pay for healthcare coverage for anyone listed above?

☐ ☐ Did you pay for healthcare coverage for anyone not listed above?

If you had coverage for any part of the year:

Where was the policy obtained?

☐ Employer ☐ Medicare ☐ Medicaid ☐ Marketplace (Exchange) ☐ Other

If you didn't have coverage part or all of the year:

Answer YES if the following applies to any member of the household

☐ ☐ Was your previous insurance policy canceled or

☐ ☐ Was coverage offered by your employer or your spouse's employer?

☐ ☐ Are you a member of a federally recognized Indian tribe?

☐ ☐ Are you eligible for services through an Indian healthcare provider?

☐ ☐ Are you a member of a healthcare sharing ministry?

☐ ☐ Did you live in the United States the entire year?

☐ ☐ Are you enrolled in TRICARE?

☐ ☐ Did you apply for CHIP coverage?

☐ ☐ Do any of the following apply to you? Do NOT indicate which one.

- Became homeless
- Evicted in the past six months, or facing eviction or foreclosure
- Received a shut-off notice from a utility company
- Recently experienced domestic violence
- Recently experienced the death of a close family member
- Recently experienced a fire, flood, or other natural or human-caused disaster that resulted in substantial damage to your property
- Filed for bankruptcy in the last six months
- Incurred unreimbursed medical expenses in the last 24 months that resulted in substantial debt
- Experienced unexpected increases in essential expenses due to caring for an ill, disabled, or aging family member

Additional Deductions

Name:

SSN:

Additional Deductions

	2025 Taxpayer	2024 Taxpayer	2025 Spouse	2024 Spouse
Enter any income from Puerto Rico that you excluded				
Enter the amount from Form 4563, Line 15				
If Form W-2, Box 5, is \$176,100 or less, enter qualified tips included in				
Form W-2, Box 7.				
Qualified Tips included on Form 4137, line 1(c)				
If you received qualified tips from one employer				
Qualified tips received in the course of a trade or business				
Qualified overtime compensation included on Form W-2, Box 1				
Qualified overtime compensation included on Form 1099-NEC, Box 1 or				
Form 1099-MISC, Box 3				

Passenger Vehicle Loan Interest

TS _____

Loan origination date _____

Outstanding principal _____

Year _____

Make _____

Model _____

Vehicle identification number (VIN) _____

Business interest _____

Personal Interest _____

TS _____

Loan origination date _____

Outstanding principal _____

Year _____

Make _____

Model _____

Vehicle identification number (VIN) _____

Business interest _____

Personal Interest _____

TS _____

Loan origination date _____

Outstanding principal _____

Year _____

Make _____

Model _____

Vehicle identification number (VIN) _____

Business interest _____

Personal Interest _____

TS _____

Loan origination date _____

Outstanding principal _____

Year _____

Make _____

Model _____

Vehicle identification number (VIN) _____

Business interest _____

Personal Interest _____

Other Income and Adjustments

Name: _____

SSN: _____

Other Income

	2025 Taxpayer	2025 Spouse
Social Security Benefits (attach Forms 1099-SSA)	_____	_____
Railroad Retirement Benefits (attach Forms 1099-RRB)	_____	_____
State income tax refund (attach Forms 1099-G)	_____	_____
Alimony received		
Divorce or separation date _____ Amount _____	_____	_____
Unemployment compensation (attach Forms 1099-G)	_____	_____
Unemployment compensation repaid in 2025	_____	_____
Gambling winnings (attach Forms W2-G)	_____	_____
Alaska Permanent Fund	_____	_____
Jury duty pay	_____	_____
ABLE distributions	_____	_____
Scholarships or grants not reported on Form W-2	_____	_____
Other income: _____	_____	_____
_____	_____	_____
_____	_____	_____

Adjustments

	2025 Taxpayer	2025 Spouse
Educator expenses (If you are an educator, enter the amount you paid for classroom supplies)	_____	_____
Contributions made to a Health Savings Account (HSA)	_____	_____
Payments made for Self-Employed Health Insurance for you, your spouse, or dependents	_____	_____
Alimony paid		
Name _____		
SSN _____ Divorce or separation date _____	_____	_____
Name _____		
SSN _____ Divorce or separation date _____	_____	_____
Contributions made to a Self-Employed Pension plan (SEP), SIMPLE, or Solo 401K	_____	_____
Contributions made to an Individual Retirement Account (IRA)	_____	_____
Contributions made to a Roth IRA	_____	_____
Interest paid on a student loan	_____	_____
Other adjustments: _____	_____	_____