



YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC. FILL OUT IN BLACK INK.

FILE YOUR RETURN ELECTRONICALLY FOR A FASTER REFUND. GO TO MASS.GOV/DOR FOR MORE INFORMATION.

Massachusetts Department of Revenue Form 1 Massachusetts Resident Income Tax Return

2018

TAXPAYER'S FIRST NAME, M.I., LAST NAME, TAXPAYER'S SOCIAL SECURITY NUMBER, SPOUSE'S FIRST NAME, M.I., LAST NAME, SPOUSE'S SOCIAL SECURITY NUMBER, MAILING ADDRESS, CITY/TOWN, STATE, ZIP, FOREIGN PROVINCE/STATE/COUNTRY, FOREIGN COUNTRY (OR COUNTRY CODE), FOREIGN POSTAL CODE

Fill in if (see instructions): Original return, Amended return, Amended return due to federal change, State Election Campaign Fund, \$1 Taxpayer, \$1 Spouse, Total \$, Fill in if veteran of U.S. armed services, Fill in appropriate oval(s) if taxpayer(s) is deceased, Fill in if under age 18, Fill in if name or address has changed since 2017

a Total federal income (from U.S. Form 1040, line 6) a, b Total federal adjusted gross income (from U.S. Form 1040, line 7) b

1 FILING STATUS. Fill in one only. Single, Married filing joint return (both must sign return), Married filing separate return (must enter spouse's name and Social Security number in the appropriate areas above), Head of household (see instructions), You are a custodial parent who has released claim to exemption for child(ren), Fill in if noncustodial parent, Fill in if filing Schedule TDS (see instructions)

2 EXEMPTIONS. a. Personal exemptions. If single or married filing separately, enter \$4,400. If head of household, enter \$6,800. If married filing jointly, enter \$8,800. 2a, b. Number of dependents (do not include yourself or your spouse). Enclose Schedule DI. Total x \$1,000 = 2b, c. Age 65 or over before 2019. You, Spouse. Total x \$ 700 = 2c, d. Blindness. You, Spouse. Total x \$2,200 = 2d, e. Medical/dental (from U.S. Schedule A, line 4). 2e, f. Adoption. See instructions. 2f, g. TOTAL EXEMPTIONS. Add lines 2a through 2f. Enter here and on line 18. 2g

SIGN HERE. Under penalties of perjury, I declare that to the best of my knowledge and belief this return and enclosures are true, correct and complete. YOUR SIGNATURE, DATE, SPOUSE'S SIGNATURE, DATE

Be sure to enclose any forms or schedules (W-2, W-2G, 1099, 3K-1, SK-1, PWH or LOA) that show Massachusetts withholding.



TAXPAYER'S FIRST NAME M.I. LAST NAME

TAXPAYER'S SOCIAL SECURITY NUMBER

INCOME

3 Wages, salaries, tips and other employee compensation (from all Forms W-2)
4 Taxable pensions and annuities. See instructions
5 a. Massachusetts bank interest Exemption amount. If married filing jointly, enter \$200; otherwise enter \$100.
6 a. Business income or loss. Enclose Schedule C.
6 b. Farming income or loss. Enclose U.S. Schedule F.
7 If you are reporting rental, royalty, REMIC, partnership, S corporation, or trust income or loss, see instructions
8 a. Unemployment compensation. See instructions.
8 b. Massachusetts state lottery winnings.
9 Other income from Schedule X, line 5. Enclose Schedule X; not less than "0".
10 TOTAL 5.1% INCOME. Add lines 3 through 9. Be sure to subtract any losses in lines 6 or 7

DEDUCTIONS

11 a. Amount you paid to Social Security, Medicare, Railroad, U.S. or Massachusetts retirement. Not more than \$2,000
11 b. Amount spouse paid to Social Security, Medicare, Railroad, U.S. or Massachusetts retirement. Not more than \$2,000.
12 Child under age 13, or disabled dependent/spouse care expenses (from worksheet).
13 Dependent member(s) of household under age 12, or dependent(s) age 65 or over (not you or your spouse) as of December 31, 2018, or disabled dependent(s) (only if single, head of household or married filing joint return and not claiming line 12).
14 Rental deduction. Total rental deduction cannot exceed \$3,000 (\$1,500 if married filing separately). See instructions.
15 Other deductions from Schedule Y, line 19. Enclose Schedule Y
16 TOTAL DEDUCTIONS. Add lines 11 through 15
17 5.1% INCOME AFTER DEDUCTIONS. Subtract line 16 from line 10. Not less than "0".
18 Total exemption amount (from line 2g).
19 5.1% INCOME AFTER EXEMPTIONS. Subtract line 18 from line 17. Not less than "0." If line 17 is less than line 18, see instructions.
20 INTEREST AND DIVIDEND INCOME from Schedule B, line 38. Not less than "0." Enclose Schedule B
21 TOTAL TAXABLE 5.1% INCOME. Add lines 19 and 20



TAXPAYER'S FIRST NAME

M.I. LAST NAME

TAXPAYER'S SOCIAL SECURITY NUMBER

Grid for Taxpayer's First Name, M.I., and Last Name

Grid for Taxpayer's Social Security Number

22 TAX ON 5.1% INCOME (from tax table). If line 21 is more than \$24,000, multiply by .051. Note: If choosing the optional 5.85% tax rate, fill in oval and see instructions

Grid for line 22 with 00 in the last two columns

23 12% INCOME (from Schedule B, line 39). Not less than "0." Enclose Schedule B.

a. 00 x .12 = 23

Grid for line 23 with 00 in the last two columns

24 TAX ON LONG-TERM CAPITAL GAINS (from Schedule D, line 22). Not less than "0." Enclose Schedule D. If filing Schedule D-IS, Installment Sales, fill in oval and enclose Schedule D-IS. If excess exemptions were used in calculating lines 20, 23 or 24, fill in oval and see instructions.

Grid for line 24 with 00 in the last two columns

25 Credit recapture amount. Enclose Schedule CRS. See instructions

Grid for line 25 with 00 in the last two columns

26 Additional tax on installment sales. See instructions

Grid for line 26 with 00 in the last two columns

27 If you qualify for No Tax Status, fill in oval and enter "0" on line 28 (from worksheet).

Grid for line 27 with 00 in the last two columns

28 TOTAL INCOME TAX. Add lines 22 through 26

Grid for line 28 with 00 in the last two columns

CREDITS

29 Limited Income Credit (from worksheet)

Grid for line 29 with 00 in the last two columns

30 Income tax due to another state or jurisdiction (from worksheet). Not less than "0." Enclose Schedule OJC.

Grid for line 30 with 00 in the last two columns

31 Other credits (from Schedule CMS)

Grid for line 31 with 00 in the last two columns

32 INCOME TAX AFTER CREDITS. Subtract total of lines 29 through 31 from line 28. Not less than "0"

Grid for line 32 with 00 in the last two columns

33 Voluntary fund contributions

a. Endangered Wildlife Conservation 33a

Grid for line 33a with 00 in the last two columns

b. Organ Transplant 33b

Grid for line 33b with 00 in the last two columns

c. Massachusetts AIDS 33c

Grid for line 33c with 00 in the last two columns

d. Massachusetts U.S. Olympic 33d

Grid for line 33d with 00 in the last two columns

e. Massachusetts Military Family Relief 33e

Grid for line 33e with 00 in the last two columns

f. Homeless Animal Prevention And Care 33f

Grid for line 33f with 00 in the last two columns

Total. Add lines 33a through 33f 33

Grid for line 33 with 00 in the last two columns

34 Use tax due on Internet, mail order and other out-of-state purchases (from worksheet) 34

Grid for line 34 with 00 in the last two columns

35 Health Care penalty. Not less than "0" (from worksheet). Enclose Schedule HC.

a. You 00 b. Spouse 00 c. Federal healthcare penalty 00

Total a + b - c = 35

36 AMENDED RETURN ONLY. Overpayment from original return. Not less than "0." See instructions 36

Grid for line 36 with 00 in the last two columns

37 INCOME TAX AFTER CREDITS, CONTRIBUTIONS, USE TAX and HC PENALTY. Add lines 32 through 36 37

Grid for line 37 with 00 in the last two columns



TAXPAYER'S FIRST NAME M.I. LAST NAME

TAXPAYER'S SOCIAL SECURITY NUMBER

MASSACHUSETTS WITHHOLDING, PAYMENTS AND REFUNDABLE CREDITS

38 Massachusetts income tax withheld. Be sure to enclose any forms or schedules (W-2, W-2G, 2G, 1099, 3K-1, SK-1, PWH-WA or LOA) that show Massachusetts withholding.38

39 2017 overpayment applied to your 2018 estimated tax (from 2017 Form 1, line 47 or Form 1-NR/PY, line 51). Do not enter 2017 refund.39

40 2018 Massachusetts estimated tax payments. Do not include line 39 amount40

41 Payments made with extension41

42 AMENDED RETURN ONLY. Payments made with original return. Not less than "0." See instructions.42

43 EARNED INCOME CREDIT. a. Number of qualifying children b. Amount from U.S. return 43b x .23 = 43

Note: You cannot claim the Earned Income Credit if your filing status is married filing separately unless you qualify for an exception (see instructions). Fill in oval if you qualify for this exception.

44 Senior Circuit Breaker Credit. Enclose Schedule CB 44

45 Other refundable credits (from Schedule CMS)45

46 TOTAL. Add lines 38 through 4546

47 OVERPAYMENT. If line 37 is smaller than line 46, subtract line 37 from line 46. If line 37 is larger than line 46, go to line 50. If line 37 and line 46 are equal, enter "0" in line 4947

48 Amount of overpayment you want APPLIED to your 2019 ESTIMATED TAX.48

49 THIS IS YOUR REFUND. Subtract line 48 from line 47. Mail to: Massachusetts DOR, PO Box 7000, Boston, MA 02204.49

Direct deposit of refund. See instructions. Type of account (select one): Checking Savings

Routing number (first two digits must be 01 to 12 or 21 to 32) Account number

50 TAX DUE. Subtract line 46 from line 37. Pay in full online at mass.gov/masstaxconnect50

Or pay by mail. Make check payable to Commonwealth of Massachusetts. Write Social Security number(s) in memo section of check and be sure to sign check. Mail to: Massachusetts DOR, PO Box 7003, Boston, MA 02204.

These amounts will affect your refund or tax due:

Interest Penalty M-2210 amount Exception. Enclose Form M-2210.

PRINT PAID PREPARER'S NAME PAID PREPARER'S SSN or PTIN PAID PREPARER'S PHONE DATE PAID PREPARER'S SIGNATURE PAID PREPARER'S EIN

Fill in if self-employed DOR may discuss this return with the preparer I do not want my preparer to file my return electronically

BE SURE TO SIGN RETURN ON PAGE 1 AND ENCLOSE SCHEDULE HC. FOR PRIVACY ACT NOTICE, SEE INSTRUCTIONS.



FULL-YEAR RESIDENTS AND CERTAIN PART-YEAR RESIDENTS MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH RETURN

TAXPAYER'S FIRST NAME, M.I., LAST NAME, TAXPAYER'S SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2018

1 a. Date of birth, b. Spouse's date of birth, c. Family size. See instructions

2 Federal adjusted gross income (required information; from U.S. Form 1040, line 7). If married filing separately, see instructions 2 [X] 00

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). See Form MA 1099-HC from your insurer or Schedule HC instructions. You must fill in an oval. a. You, b. Spouse

If you filled in "Full-year MCC" or "Part-year MCC," go to line 4. If you filled in "No MCC/None," go to line 6.

4 Indicate the health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements in which you were enrolled in 2018. See Form MA 1099-HC from your insurer or Schedule HC instructions. Check all that apply. a. Private insurance, including ConnectorCare. Complete lines 4f and/or 4g below 4a, b. MassHealth. Fill in oval(s) and go to line 5 4b, c. Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5. 4c, d. U.S. military (including Veteran's Administration and Tri-Care). Fill in oval(s) and go to line 5. 4d, e. Other government program. Enter program name(s) only in lines 4f and/or 4g below 4e

4f YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. Fill in if you were not issued Form MA 1099-HC.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

4g SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. Fill in if you were not issued Form MA 1099-HC.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) SUBSCRIBER NUMBER (from Form MA 1099-HC)

5 Skip the remainder of this schedule and continue completing your return if you had health insurance that met MCC requirements for the full year, including private insurance, MassHealth or ConnectorCare; or if, at any point during 2018, you had Medicare (including supplement or replacement plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance. You are not subject to a penalty.

You must complete and enclose this Schedule HC with your return.

IF YOU HAD HEALTH INSURANCE THAT MET MCC REQUIREMENTS FOR THE FULL YEAR, INCLUDING PRIVATE INSURANCE, MASSHEALTH OR CONNECTORCARE, OR IF YOU HAD MEDICARE, U.S.MILITARY OR OTHER GOVERNMENT INSURANCE AT ANY POINT DURING 2018, YOU ARE NOT SUBJECT TO A PENALTY. SKIP THE REMAINDER OF SCHEDULE HC AND CONTINUE COMPLETING YOUR TAX RETURN.



TAXPAYER'S FIRST NAME

M.I. LAST NAME

TAXPAYER'S SOCIAL SECURITY NUMBER

Grid for entering taxpayer's first name, middle initial, and last name.

Grid for entering taxpayer's social security number.

Schedule HC Uninsured for All or Part of 2018. Do not complete if you are not subject to a penalty.

6 Was your income in 2018 at or below 150% of the federal poverty level? (See worksheet) 6 Yes No
If you answer **Yes**, you are not subject to a penalty in 2018. Skip the remainder of this schedule and complete your tax return. If you answer **No** and you were enrolled in a health insurance plan that met the Minimum Creditable Coverage (MCC) requirements for part, but not all, of 2018, go to line 7. If you answer **No** and you had no insurance or you were enrolled in a plan that did not meet the MCC requirements during the period that the mandate applied, go to line 8a.

7 Complete this section **only** if you, and/or your spouse if married filing jointly, were enrolled in a health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements for part, but not all of 2018. Fill in the ovals below for the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in the ovals for the months you were covered by a plan that met the MCC requirements at least **15 days or more**. If, during 2018, you **turned 18**, you were a **part-year resident** or a taxpayer was **deceased**, fill in the oval(s) below for the month(s) that met the MCC requirements during the period that the mandate applied. See instructions.

You may **only** fill in the oval(s) for the month(s) you had health insurance that met MCC requirements. If you had health insurance, but it did not meet MCC requirements, you must skip this section and go to line 8a.

MONTHS COVERED BY HEALTH INSURANCE THAT MET MINIMUM CREDITABLE COVERAGE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
You:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spouse:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

If you had four or more consecutive months either with no insurance or insurance that did not meet the MCC requirements (four or more blank ovals in a row), go to line 8a. Otherwise, a penalty does not apply to you in 2018. **You are not subject to a penalty in 2018. Skip the remainder of this schedule and complete your tax return.**

Schedule HC Religious Exemption and Certificate of Exemption

Do not complete if you are not subject to a penalty.

8 a. **Religious exemption.** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely-held religious beliefs that cause you to object to substantially all forms of treatment covered by health insurance?

8a. You Yes No
Spouse Yes No

If you answer **Yes**, go to line 8b. If you answer **No**, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2018 tax year?

8b. You Yes No
Spouse Yes No

If you answer **No** to line 8b, **you are not subject to a penalty in 2018. Skip the remainder of this schedule and continue completing your tax return.** If you answer **Yes** to line 8b, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

9 **Certificate of exemption.** Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2018 tax year?

9. You Yes No
Spouse Yes No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2018, issued by the Federal Health Insurance Marketplace, do not enter that information in line 9.

If you answer **Yes**, enter the certificate number below, **you are not subject to a penalty in 2018. Skip the remainder of this schedule and continue completing your tax return.** If you answer **No** to line 9, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR MASSACHUSETTS CERTIFICATE NUMBER

SPOUSE'S MASSACHUSETTS CERTIFICATE NUMBER

Grid for entering your Massachusetts certificate number.

Grid for entering spouse's Massachusetts certificate number.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.



TAXPAYER'S FIRST NAME

M.I. LAST NAME

TAXPAYER'S SOCIAL SECURITY NUMBER

Grid for entering taxpayer's first name, M.I., and last name.

Grid for entering taxpayer's social security number.

Schedule HC Affordability as Determined By State Guidelines

Do not complete if you are not subject to a penalty.

Note: This section will require the use of worksheets and tables. You must complete the worksheet(s) to determine if health insurance was affordable to you during the 2018 tax year.

10 Did your employer offer affordable health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10?

10. You Yes No
Spouse Yes No

If your employer did not offer health insurance that met the minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed, fill in the **No** oval.

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

11 Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11?

11. You Yes No
Spouse Yes No

If you answer **No**, go to line 12. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

12 Were you able to purchase affordable private health insurance that met the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12?

12. You Yes No
Spouse Yes No

If you answer **No**, you are not subject to a penalty. **Continue completing your tax return.** If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

Schedule HC Complete Only If You Are Filing an Appeal

You must complete the Health Care Penalty Worksheet to determine your penalty amount before completing this section.

You may have grounds to appeal if you were unable to obtain affordable insurance that met the minimum creditable coverage requirements in 2018 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. If you believe you have grounds for appealing the penalty, fill in the oval(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the oval below, you (or your spouse if married filing jointly) are authorizing DOR to share information from your tax return, including this schedule, with the Massachusetts Health Connector for purposes of deciding your appeal.

Note: You may also be subject to a separate federal penalty if you were uninsured. Visit irs.gov for more information on the federal requirements.

If you are subject to a federal penalty, you must enter that amount on Form 1, line 35c or Form 1-NR/PY, line 39c.

Important information if you are filing an appeal:

You will receive a follow-up letter asking you to state your grounds for appeal in writing, and submit supporting documentation. Failure to respond to that letter within the time specified in the letter will lead to dismissal of your appeal and will result in a future assessment of a penalty.

Once your documentation is received, it will be reviewed by the Massachusetts Health Connector and you may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do not assess yourself or enter a penalty amount on your Form 1 or Form 1-NR/PY. Also, do not include any hardship documentation with this return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

You: I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.

Spouse: I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.