

Client Tax Information Sheet



1620 Elton Road, Suite 204
Silver Spring, MD 20903
Phone: (301) 589-2040
Fax: (301) 589-2042

Email: integratedmultiservices@gmail.com
Website: www.integratedmultiservices.com

Tax Year: _____

ARE YOU A NEW CLIENT? YES NO

REFERRED BY: _____

*****Please Fill Out Each Question Completely**

SECTION 1		PERSONAL INFORMATION	
Taxpayer's Name			
Social Security / ITIN Number		Occupation	
Marital Status Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widow <input type="checkbox"/>			
Street Address			Apt#
City		State	Zip
Home Phone No.		Cell Phone No.	
Date of Birth: month _____ day _____ year _____		Email Address:	
Blind: Yes <input type="checkbox"/> No <input type="checkbox"/>		Full time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Can you be claimed as a dependent on another's return?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you file a federal tax return last year? Yes <input type="checkbox"/> No <input type="checkbox"/>		A state tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you itemize your deductions last year? Yes <input type="checkbox"/> No <input type="checkbox"/>			
SPOUSE INFORMATION (Complete only if legally married)			
Joint Taxpayer's Name (Spouse)			
Social Security Number		Occupation	
Home Phone No.		Cell Phone No.	
Date of Birth: month _____ day _____ year _____		Email Address:	
Blind: Yes <input type="checkbox"/> No <input type="checkbox"/>		Full time Student: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Occupation			
Can you be claimed as a dependent on another's return?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you file a federal tax return last year? Yes <input type="checkbox"/> No <input type="checkbox"/>		A state tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you itemize your deductions last year? Yes <input type="checkbox"/> No <input type="checkbox"/>			
SECTION 2		DEPENDENT INFORMATION	
1 st Dependent's Name			
Social Security Number		Date of Birth	
Relationship (son, daughter, niece, etc.)		Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of months they lived in your home in 2019		Disabled Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dependent have income over \$1000? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dependent required to file a tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	
2nd Dependent's Name			
Social Security Number		Date of Birth	
Relationship (son, daughter, niece, etc.)		Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of months they lived in your home in 2019		Disabled Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dependent have income over \$1000? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dependent required to file a tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	
3rd Dependent's Name			
Social Security Number		Date of Birth	
Relationship (son, daughter, niece, etc.)		Full-time Student Yes <input type="checkbox"/> No <input type="checkbox"/>	
Number of months they lived in your home in 2019		Disabled Yes <input type="checkbox"/> No <input type="checkbox"/>	
Dependent have income over \$1000? Yes <input type="checkbox"/> No <input type="checkbox"/>		Dependent required to file a tax return? Yes <input type="checkbox"/> No <input type="checkbox"/>	

4th Dependent's Name		
Social Security Number	Date of Birth	
Relationship (son, daughter, niece, etc.)	Full-time Student	Yes__ No__
Number of months they lived in your home in 2019	Disabled	Yes __ No__
Dependent have income over \$1000? Yes __ No__		Dependent required to file a tax return? Yes __ No__

5th Dependent's Name		
Social Security Number	Date of Birth	
Relationship (son, daughter, niece, etc.)	Full-time Student	Yes__ No__
Number of months they lived in your home in 2019	Disabled	Yes __ No__
Dependent have income over \$1000? Yes __ No__		Dependent required to file a tax return? Yes __ No__

SECTION 3	INCOME
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<input type="checkbox"/> Salary / Wages - W2 <input type="checkbox"/> Self-Employed / Business Income <input type="checkbox"/> Independent Contractor- 1099 <input type="checkbox"/> Commission / Fees <input type="checkbox"/> Cash Payments <input type="checkbox"/> Unemployment \$ _____ <input type="checkbox"/> Tip Income <input type="checkbox"/> Did you sell Any Stocks/Bonds? <i>(If yes, enclosed 1099-B & cost info)</i> <input type="checkbox"/> Social Security	<input type="checkbox"/> Railroad Retirement <input type="checkbox"/> Pension / Retirement Income <input type="checkbox"/> IRA Distribution <input type="checkbox"/> Rental Property Income <input type="checkbox"/> Partnership / S-Corporation - K-1 <input type="checkbox"/> Estate / Trust - K-1 <input type="checkbox"/> Military BAS/BAH \$ _____ <input type="checkbox"/> Did you sell a personal residence? <input type="checkbox"/> Did you sell other real estate? <i>(Enclose settlement statements)</i>	<input type="checkbox"/> Lottery/Gambling Winnings – 1099-G <input type="checkbox"/> Interest - 1099-INT <input type="checkbox"/> Dividends - 1099-DIV <input type="checkbox"/> Mutual Fund Distributions - 1099 <input type="checkbox"/> Municipal Bonds <input type="checkbox"/> Farm Income <input type="checkbox"/> Other Income (Enclose Details) <input type="checkbox"/> Installment Sale <input type="checkbox"/> Sell Any Business Assets? <i>(Enclose sale and original cost info)</i>
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SECTION 4	DEDUCTIONS/CREDITS
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Do you have any child care expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount Paid \$ _____
Name of Care Provider _____ Phone # _____	
Address _____	
City/ State/ Zip _____ Employer ID # or Social Security # _____	

Do you have tuition fees ? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount \$ _____	For Who?: _____
Name of School _____		
Address _____		
City/ State/ Zip _____		Federal ID # _____

Do you have any student loan interest deductions Yes <input type="checkbox"/> No <input type="checkbox"/>	Total Amount: \$ _____
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Do you have any IRA deductions? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount \$ _____
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Did you pay interest and property taxes on your home? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount \$ _____
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Did you have un-reimbursed medical and dental expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: \$ _____
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Did you have charitable contributions expenses? Yes <input type="checkbox"/> No <input type="checkbox"/>	Amount: \$ _____
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If additional space is needed, number and insert below

SECTION 5**DIRECT DEPOSIT INFORMATION**

Please provide the following information so that your refund can be deposited into your bank account:

Bank Name _____
 State where your account was opened: _____
 Routing Transit Number (RTN) _____ (leave blank if uncertain)
 Your Account Number _____
 Account Type: Checking Savings

I (We, *if filing jointly*) acknowledge that the above information provided by me is true and accurate to the best of my/our knowledge. I hereby relieve IMS Tax Services from any liability whatsoever, regarding the preparation of this/these tax return(s), and agree to hold them harmless from any damages I may suffer and understand that my sole relief is limited to the return of any fees paid for the preparation of these documents.

Primary Taxpayer's Signature _____ Date _____

Print Name _____

Spouse's Signature _____ Date _____

Print Name _____

OFFICE USE ONLY

Interviewer: _____ Preparer: _____

Completion date: _____ E- file Date: _____

Notes:

ALL FORMS SIGNED?



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COMPANY POLICY AGREEMENT

(Please read the following and sign below)

1. Your return(s) prepared by *IMS Tax Services* is/are based solely on the information collected and provided by you. You are responsible for any incomplete or inaccurate information provided therein.
2. The IRS and/or your state may examine your return(s) and this may cause your tax refund(s) to be delayed. The Earned Income Tax Credit or Child Tax Credit portion of your refund(s) may be a reason for the IRS and/or your state to delay the issuance of part or all of your refund(s).
3. Once your return(s) is/are accepted by the IRS and/or your state, *IMS Tax Services* is unable to determine if your refund(s) may be delayed and/or for how long. You must contact the IRS or your state for answers to your questions.
4. If further services are needed due to tax issue(s) such as an audit, examination or etc. an additional cost will be required.
5. You have been hereby provided with a copy of your federal and state tax returns. Additional copies can be provided at a cost of \$15.00 per year.
6. If the IRS and/or your state holds, garnishes, rejects or denies your refund(s) for any reason, you are still responsible for tax preparation fees and/or other *IMS Tax Services* fees listed on your attached invoice. There will be a \$50.00 late fee assessed to your account for open unpaid balances over 90 days.

Taxpayer Signature: _____ Date: _____

Joint Taxpayer Signature: _____ Date: _____

IMPORTANT NUMBERS – To check the status of your refund(s):

- Internal Revenue Service (IRS) – 1-800-829-1040 or www.irs.gov
- Comptroller of Maryland (MD State) – 1-410-260-7980 or www.comp.state.md.us
- DC Office of Tax & Revenue Service (DC) – 202-727-4TAX (4829) or www.dc.gov
- Virginia Department of Taxation – 804-367-2486 or www.tax.virginia.gov
- ITIN Unit (Tax ID) – 1-800-908-9982
- Financial Management Services (check to see if refund will be offset) – 1-800-304-3107

Office Use Only:

*Federal Refund: \$ _____

*MD State Refund: \$ _____ *VA State Refund: \$ _____ *DC State Refund: \$ _____

Itemized Deductions Worksheet



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Itemized deductions (List amounts and provide receipts, checks, bank statements or other documentation)			
MEDICAL/DENTAL EXPENSES		INTEREST PAID	
Medical Insurance (<i>paid by you</i>)		Mortgage on Main Home	
Dental Insurance (<i>paid by you</i>)		Paid to Financial Institution (1098)	
Long Term Care Insurance		Paid to Individual	
Doctors (<i>co-pays</i>)		Name:	SSN:
Dentist/Orthodontist (<i>Braces, etc.</i>)		Address:	
Prescription Drugs (<i>Enclose Pharmacy Report</i>)		Points Paid on New Mortgage (<i>Enclose Settlement Statement-HUD-1</i>)	
Glasses and Contact Lenses		Home Equity Loan/Second Mortgage	
Hospitals & Emergency Visits		Mortgage on Second Home	
Surgical Procedure		Paid to Financial Institution (1098)	
Medical Equipment Rental		Paid to Individual	
Skilled Nursing Care		Name:	
Prescribed Physical Aids		Address:	SSN:
Medicare Part B		Investment Interest paid	
Other Medical Professionals			
Other Medical (Describe)			
Medical Transportation			
Medical Miles Driven in your Vehicle		CHARITABLE CONTRIBUTIONS	
		(Receipt required for single donations of \$250.00 or more.)	
		Church/Temple/Mosque	
		United Way	
		Scouts	
		Other (list)	
STATE & LOCAL TAXES		Volunteer Mileage	
Home Real Estate Taxes		Donation of a Vehicle	
Other Real Estate Taxes		Non-Cash Contributions	
Personal Property Tax (autos, boat)		(If \$500.00 or more, enclosed receipt with name and address of organization and describe how the fair market value was determined)	
Other State or Local Tax			
CASUALTY OR THEFT LOSS (For natural disasters only)		MISCELLANEOUS DEDUCTIONS	
Type of Property:		Tax Return Preparation Fee (2019)	
Describe Loss:		Safe Deposit Box (store investments)	
Cost or Basis of Property		Investment Expense (enclose list)	
Insurance Reimbursement		Job Hunting Expenses (enclose list)	
Fair Market Value Before Loss		Gambling Losses	
Fair Market Value After Loss		Prof Association or Union Dues	