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 2017

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 (no. & street; apt./suite/postal box). If you have a foreign address, also complete line below. | CITY/TOWN | STATE | ZIP

FOREIGN PROVINCE/STATE/COUNTY | FOREIGN COUNTRY (OR COUNTRY CODE) | FOREIGN POSTAL CODE

Be sure to include state copy of Forms W-2, W-2G and 1099 (showing Massachusetts withholding.)

Fill in if (see instructions): ○ **Original return** ○ **Amended return** ○ **Amended return due to federal change**

State Election Campaign Fund (this contribution will not change your tax or reduce your refund) ○ $1 Taxpayer ○ $1 Spouse . . . . . Total $

Fill in if veteran of U.S. armed services who served in Operation Enduring Freedom, Iraqi Freedom or Noble Eagle . . . . . ○ Taxpayer ○ Spouse

Fill in appropriate oval(s) if taxpayer(s) is deceased. See instructions . . . . . ○ Taxpayer ○ Spouse

Fill in if under age 18. See instructions . . . . . ○ Taxpayer ○ Spouse

Fill in if name or address has changed since 2016. . . . . ○

▼ IF A LOSS, MARK AN X IN BOX

a Total federal income (from U.S. Forms 1040, line 22; 1040A, line 15; or 1040EZ, line 4) . . . . . a

b Total federal adjusted gross income (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4) . . . . . 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 × $1,000 = 2b

c. Age 65 or over before 2018 ○ You ○ Spouse . . . . . Total × $ 700 = 2c

d. Blindness ○ You ○ Spouse . . . . . Total × $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

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) 3

4 Taxable pensions and annuities. See instructions 4

5 a. Massachusetts bank interest b. Exemption amount. If married filing jointly, enter $200; otherwise enter $100. . . . . .a – b (not less than "0") = 5

6 a. Business/profession income/loss (see instr.) b. Farming income/loss (see instr.) a + b = 6

7 If you are reporting rental, royalty, REMIC, partnership, S corporation, or trust income or loss, see instructions . . . 7

8 a. Unemployment compensation. See instructions. 8a

b. Massachusetts state lottery winnings. 8b

9 Other income (alimony, taxable IRA/Keogh distribution, winnings, fees) from Schedule X, line 5. **Enclose** Schedule X; not less than "0". 9

10 **TOTAL 5.1% INCOME.** Add lines 3 through 9. Be sure to subtract any losses in lines 6 or 7 10

DEDUCTIONS

11 a. Amount you paid to Social Security, Medicare, Railroad, U.S. or Massachusetts retirement. **Not more than $2,000** 11a

b. Amount spouse paid to Social Security, Medicare, Railroad, U.S. or Massachusetts retirement. **Not more than $2,000**. 11b

12 Child under age 13, or disabled dependent/spouse care expenses (from worksheet). 12

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, 2017, or disabled dependent(s) (only if single, head of household or married filing joint return and not claiming line 12).
a. **Not more than two** . . . . . × $3,600 = 13

14 Rental deduction. Total rental deduction cannot exceed $3,000 ($1,500 if married filing separately). See instructions.
a. Total rent paid in 2017 . . . . . ÷ 2 = 14

15 Other deductions from Schedule Y, line 19. **Enclose** Schedule Y 15

16 **TOTAL DEDUCTIONS.** Add lines 11 through 15 16

17 **5.1% INCOME AFTER DEDUCTIONS.** Subtract line 16 from line 10. **Not less than "0"**. 17

18 Total exemption amount (from line 2g). 18

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 19

20 **INTEREST AND DIVIDEND INCOME** from Schedule B, line 38. **Not less than "0." Enclose** Schedule B 20

21 **TOTAL TAXABLE 5.1% INCOME.** Add lines 19 and 20 21

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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 22

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

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 24
If excess exemptions were used in calculating lines 20, 23 or 24, fill in oval ⬭ and see instructions.

25 Credit recapture amount. **Enclose** Credit Recapture Schedule. See instructions. 25

26 Additional tax on installment sales. See instructions 26

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

28 **TOTAL INCOME TAX**. Add lines 22 through 26 28

CREDITS

29 Limited Income Credit (from worksheet) 29

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

31 Other credits (from Credit Manager Schedule) 31

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

33 Voluntary fund contributions.

a. Endangered Wildlife Conservation 33a
b. Organ Transplant 33b
c. Massachusetts AIDS. 33c
d. Massachusetts U.S. Olympic 33d
e. Massachusetts Military Family Relief 33e
f. Homeless Animal Prevention And Care. 33f
Total. Add lines 33a through 33f 33

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

35 Health Care penalty. **Not less than "0"** (from worksheet). **Enclose** Schedule HC.
a. You b. Spouse c. Federal healthcare penalty
Total . . . . . a + b – c = 35

36 **INCOME TAX AFTER CREDITS, CONTRIBUTIONS, USE TAX** and **HC PENALTY.** Add lines 32 through 35 36

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MASSACHUSETTS WITHHOLDING, PAYMENTS AND REFUNDABLE CREDITS

37 Massachusetts income tax withheld. **Enclose** all Massachusetts Forms W-2, W-2G, 2-G, PWH-WA, LOA and certain 1099s, if applicable . . . . . .37 .00

38 2016 overpayment applied to your 2017 estimated tax (from 2016 Form 1, line 46 or Form 1-NR/PY, line 50. **Do not enter 2016 refund** . . . . . .38 .00

39 2017 Massachusetts estimated tax payments. **Do not include line 38 amount** . . . . . .39 .00

40 Payments made with extension . . . . . .40 .00

41 Payment with original return. Use only if amending a return . . . . . .41 .00

42 Earned Income Credit. a. Number of qualifying children

Amount from U.S. return .00 . . . . . × .23 = 42 .00

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 ⬭

43 Senior Circuit Breaker Credit. **Enclose** Schedule CB . . . . . 43 .00

44 Other refundable credits (from Credit Manager Schedule) . . . . . .44 .00

45 **TOTAL.** Add lines 37 through 44 . . . . . .45 .00

46 **OVERPAYMENT.** If line 36 is **smaller** than line 45, subtract line 36 from line 45. If line 36 is **larger** than line 45, go to line 49. If line 36 and line 45 are equal, enter "0" in line 48 . . . . . .46 .00

47 Amount of overpayment you want **APPLIED to your 2018 ESTIMATED TAX** . . . . . .47 .00

48 **THIS IS YOUR REFUND.** Subtract line 47 from line 46. REFUND .00

Mail to: **Massachusetts DOR, PO Box 7000, Boston, MA 02204** 48

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 . . . . . .

49 **TAX DUE.** Subtract line 45 from line 36. **Pay in full online at mass.gov/masstaxconnect** . . . . . .49 .00

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.**

Add to total in line 49, if applicable:

Interest .00 Penalty .00 M-2210 amount .00

⬭ 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 ⬭

May DOR discuss this return with the preparer? ⬭ Yes ⬭ No

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. **2017**

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. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4). If marriedt 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	Full-year MCC	Part-year MCC	No MCC/None
b. Spouse	Full-year MCC	Part-year MCC	No MCC/None

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 2017. 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	You	Spouse
b. MassHealth. Fill in oval(s) and go to line 5	4b	You	Spouse
c. Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5	4c	You	Spouse
d. U.S. military (including Veteran's Administration and Tri-Care). Fill in oval(s) and go to line 5	4d	You	Spouse
e. Other government program. Enter program name(s) only in lines 4f and/or 4g below	4e	You	Spouse

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 2017, 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 2017, 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

Schedule HC Uninsured for All or Part of 2017. Do not complete if you are not subject to a penalty.

6 Was your income in 2017 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 2017. 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 2017, 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 2017. 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 2017, 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:	○	○	○	○	○	○	○	○	○	○	○	○
Spouse:	○	○	○	○	○	○	○	○	○	○	○	○

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 2017. **You are not subject to a penalty in 2017. 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 2017 tax year?

8b. You ○ Yes ○ No
Spouse ○ Yes ○ No

If you answer **No** to line 8b, **you are not subject to a penalty in 2017. 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 2017 tax year?

9. You ○ Yes ○ No
Spouse ○ Yes ○ No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2017, 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 2017. 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

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

TAXPAYER'S FIRST NAME | M.I. | LAST NAME | 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 2017 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 2017 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.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.