



Samaritan Members who are residents of District of Columbia

This is a reminder regarding the District of Columbia's law requiring residents to purchase health insurance, and the special provision for members of sharing ministries like Samaritan Ministries. This new law requires residents to document their compliance when filing each year's District of Columbia tax return, to avoid paying a health care shared responsibility fee. Residents of the District of Columbia must provide this documentation by completing "Schedule HSR DC Health Care Shared Responsibility," a tax form that must be enclosed with your Form D-40, District of Columbia Resident Income Tax Return. Below, you will find detailed instructions and a sample of completed pages 1 and 2 of Form D-40 and page 1 of Schedule HSR DC Health Care Shared Responsibility.

Tax Year 2020 Instructions for Schedule HSR DC & Form D-40 for Samaritan members

- **At the top of Schedule HSR DC:** Enter your phone number, taxpayer identification number (TIN), date of birth, full name, and mailing address.

Part I: Because Samaritan Ministries is not health insurance, most Samaritan members will answer "No." If you answer "No," proceed to Part II. If you answer "Yes," you may stop, mark the oval on Line 3 of the D-40, and enter zero on Line 24 of your D-40.

- **Questions 2-4:** The answers you provide for questions 2-4 will determine if you need to fill out questions 5 and 6.
 - If you answer "Yes" to any of the questions from 2-4, mark the oval on Line 3 of the D-40 and enter zero on Line 24 of your D-40.
 - If you did not answer "Yes" to any of questions 2-4, proceed to questions 5 and 6.
- **Question 5:** You will likely select "No" to the exemption due to religious beliefs. That exemption is only for those with Christian Scientist-like

beliefs regarding medical care. If you select "Yes" and later receive medical care, you may be fined.

- **Question 6:** As a Samaritan member, you will select "Yes" to claim your health care sharing exemption.

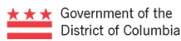
Part III:

- Enter your last name and TIN at the top of the page.
- Enter full name, TIN, Exemption Type, (this will be "D"), and the number of exempt months for each person for whom you are claiming the exemption.
- If you have more dependents than space allows in this section, print or make a second copy of page 2; be sure to enter your last name and primary TIN at the top, and then continue by listing your remaining dependents. Please note: the barcode at the top of this form is unique, so you will need to make the second copy or print from the same PDF file. Do not download a new PDF, as this would create a different barcode.

Part IV:

- If you are only claiming the exemption for part of 2020, complete Part IV and enter the total amount on Line 24 of D-40.

If you have general questions regarding health care sharing ministries and taxes, please contact us at taxquestion@samaritanministries.org. For more specific tax questions, please consult your tax adviser.



2020 D-40 Individual Income Tax Return



Important: Print in CAPITAL letters using black ink.

Personal information *Fill in if: Filing an amended return. See instructions.* OFFICIAL USE ONLY Vendor ID#0000

Your telephone number **000 123 4567**

Your taxpayer identification number (TIN) **012345678** and Date of Birth (MMDDYYYY) **01011800** Spouse's/registered domestic partner's TIN **001234567** and Date of Birth (MMDDYYYY) **01021800**

Your first name **JOE** M.I. Last name **E PERSON** *Fill in if Deceased*

Spouse's/registered domestic partner's first name **JANE** M.I. Last name **D PERSON** *Fill in if Deceased*

Home address (number, street and suite/apartment number if applicable)
123 ANY STREET

City **ANYWHERE** State **DC** Zip Code +4 **00000 0000**

Email Address

Filing status

1 *Fill in only one:* Single, Married filing jointly, Married filing separately, Dependent claimed by someone else
 Married filing separately on same return *Enter combined amounts for Lines 5–41. See instructions.*
 Registered domestic partners filing jointly or filing separately on same return *Enter combined amounts for Lines 5-41. See instructions.*
 Head of household *Enter qualifying dependent and/or non-dependent information on Schedule S.*
 Qualifying widow(er) with dependent child *Enter qualifying dependent and/or non-dependent information on Schedule S.*

2 *Fill in if you are:* Part-year resident in DC from to *See instructions.*
(MMDDYYYY) (MMDDYYYY)

3 *Fill in ONLY if Full-year health care coverage or exempt, see instructions*

● Complete your federal return first – Enter your dependents' information on DC Schedule S ●

Income Information

Round cents to nearest dollar. If amount is zero, leave line blank; if minus, enter amount and fill in oval.

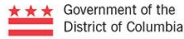
a	Wages, salaries, unemployment compensation and/or tips, <i>see instructions.</i>	a	\$							00
b	Business income or loss, <i>see instructions.</i>	Fill in if loss	<input type="radio"/>	b	\$					00
c	Capital gain or loss.	Fill in if loss	<input type="radio"/>	c	\$					00
d	Rental real estate, royalties, partnerships, etc.	Fill in if loss	<input type="radio"/>	d	\$					00

Computation of DC Gross and Adjusted Gross Income

4 Federal adjusted gross income. From adjusted gross income lines on federal Forms 1040, 1040-SR, 1040-NR or 1040-NR-EZ. *Fill in if loss* **4** \$ **00**

STAPLE OTHER DOCUMENTS IN UPPER LEFT IN BACK

STAPLE W-2s AND ANY OTHER WITHHOLDING STATEMENTS HERE



2020

SCHEDULE HSR
DC Health Care
Shared Responsibility



2 0 0 4 0 0 2 1 0 0 0 0

Important: Print in CAPITAL letters using black ink. File with your D-40.

OFFICIAL USE ONLY Vendor ID#0000

Personal information
Your daytime telephone number 000 123 4567
Your taxpayer identification number (TIN) and Date of Birth (MMDDYYYY) 01234567801011800 Spouse's/registered domestic partner's TIN and Date of Birth (MMDDYYYY) 00123456701021800
Your first name M.I. Last name
JOE E PERSON
Spouse's/registered domestic partner's first name M.I. Last name
JANE D PERSON
Mailing address (number, street and suite/apartment number if applicable)
123 ANY STREET
City State Zip Code +4
ANYWHERE DC 00000 0000

PART I Do you have qualifying health coverage?

- 1 Did you and, if applicable, all members of your health care shared responsibility family have qualifying health coverage for every month in 2020?
 Yes. **STOP.** You do not owe a health care shared responsibility payment. Enter zero on Line 24 of your D-40.
 No. If you answered No, complete Part II.

PART II Do you have an exemption?

- 2 Can someone else claim you as a dependent on their federal income tax return for 2020?
 Yes. **STOP.** You do not owe a health care shared responsibility payment.
 No.
- 3 Was your federal adjusted gross income below the applicable filing threshold for your filing status for 2020? See instructions.
 Yes. **STOP.** You do not owe a health care shared responsibility payment.
 No.
- 4 Was your federal adjusted gross income reported on your D-40, Line 4 for 2020 equal to or less than \$28,327?
 Yes. **STOP.** You do not owe a health care shared responsibility payment.
 No.

If you answered Yes to any of questions 2 - 4, enter zero on Line 24 of your D-40. If not, continue by answering questions 5 - 6.

- 5 Do you affirm under the penalties of perjury that you or any member of your health care shared responsibility family lacked qualifying health coverage in 2020 on the basis of a sincerely held religious belief during the entire taxable year?
 Yes. You must complete Part III before completing Part IV.
 No.
- 6 Are you claiming an exemption (other than a sincerely held religious belief) for at least one month for 2020 for yourself or any member of your health care shared responsibility family?
 Yes. You must complete Part III before completing Part IV.
 No.

After answering questions 5 - 6, complete Part IV to determine the amount to enter on Line 24 of your D-40. If you answered yes to question 5 or 6, you must also complete Part III.



Enter your last name
 Enter your taxpayer identification number (TIN)

PART III What coverage exemptions are you claiming for members of your shared responsibility family and for how many months? See instructions for exemption type(s).

Name of Individual	Taxpayer Identification Number (TIN)	Exemption Type	Number of Exempt Months Claimed
7 First name and M.I. <input type="text" value="JOE"/> E Last name <input type="text" value="PERSON"/>	<input type="text" value="012345678"/>	<input type="text" value="D"/>	<input type="text" value="12"/>
8 First name and M.I. <input type="text" value="JANE"/> D Last name <input type="text" value="PERSON"/>	<input type="text" value="001234567"/>	<input type="text" value="D"/>	<input type="text" value="12"/>
9 First name and M.I. <input type="text" value="JUNIOR"/> B Last name <input type="text" value="PERSON"/>	<input type="text" value="000123456"/>	<input type="text" value="D"/>	<input type="text" value="12"/>
10 First name and M.I. <input type="text"/> Last name <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11 First name and M.I. <input type="text"/> Last name <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12 First name and M.I. <input type="text"/> Last name <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PART IV Complete the applicable worksheets before completing Part IV.

Round cents to nearest dollar.
If amount is zero, leave line blank.

13 Enter flat dollar amount (see Worksheet A-1, Line 5 or Worksheet A-2, Line 7).....	13	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	00
14 Enter the percentage income amount (see Worksheet B-1, Line 4 or Worksheet B-2, Line 14).....	14	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	00
15 Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the same, enter that number.).....	15	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	00
16 Enter the District Average Bronze Plan Premium (see Worksheet C-1, Line 2 or Worksheet C-2, Line 2).....	16	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	00
17 Enter the smaller of Line 15 or Line 16 here and on D-40, Line 24	17	\$	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	00