Form M-8453
Individual Income Tax Declaration for Electronic Filing

2017
Massachusetts Department of Revenue

Please print or type. Privacy Act Notice available upon request. For the year January 1–December 31, 2017.

Your first name and initial	Last name	Your Social Security number
LAKSHMI SUNANDA ALLURI		859-11-6062
If a joint return, spouse's first name and initial	Last name	Spouse's Social Security number

Present street address (and apartment number)
63 GOODWIN DR

City/Town/Post Office	State	Zip	Filing status:
NORTH BRUNSWICK	NJ	08902	☒ Single ☐ Married filing jointly ☐ Married filing separately ☐ Head of household

Part 1. Tax Return Information for Electronic Filing

1	Total 5.1% income (from Form 1, line 10, or Form 1-NR/PY, line 12)	36488
2	Income tax after credits (from Form 1, line 32, or Form 1-NR/PY, line 36)	1585
3	Massachusetts use tax (from Form 1, line 34, or Form 1-NR/PY, line 38)	0
4	Massachusetts income tax withheld (from Form 1, line 37, or Form 1-NR/PY, line 41)	1861
5	Refund amount (from Form 1, line 48, or Form 1-NR/PY, line 52)	276
6	Tax due (from Form 1, line 49, or Form 1-NR/PY, line 53)	

Part 2. Declaration and Signature of Taxpayer

Under pains and penalties of perjury, I declare that I have reviewed the information on my return with the information I have provided to my Electronic Return Originator and that the amounts above agree with the amounts shown on my 2017 Massachusetts return. To the best of my knowledge and belief this information is true, correct and complete. I consent that my return, including this declaration and accompanying schedules, forms and statements be sent to the Massachusetts Department of Revenue by my Electronic Return Originator. I authorize DOR to inform my Electronic Return Originator and/or the transmitter when my electronic return has been accepted. In the event that it is rejected, I authorize DOR to identify the reasons for rejection so that the return can be corrected and re-transmitted. If I have filed a balance due return, I understand that if DOR does not receive full and timely payment of my tax liability, I will remain liable for the tax liability and all applicable penalties and interest.

Your signature	Date	Spouse's signature (if joint return, **both** must sign)	Date

Part 3. Declaration and Signature of Electronic Return Originator (ERO)

I declare that I have reviewed the above taxpayer's return and that the entries on this M-8453 are complete and correct to the best of my knowledge. (Collectors are not responsible for reviewing the taxpayer's return; however, they must ensure that the M-8453 accurately reflects the data on the return.) I have obtained the taxpayer's signature before submitting this return to the Massachusetts Department of Revenue. I have provided the taxpayer with a copy of all forms and information filed with the Massachusetts Department of Revenue. If I am also the paid preparer, under pains and penalties of perjury I declare that I have examined the above taxpayer's return and accompanying schedules and statements and to the best of my knowledge and belief, they are true, correct and complete. I declare that I have verified the taxpayer's proof of account and it agrees with the name(s) shown on this form. This declaration of paid preparer (other than taxpayer) is based on all information of which the preparer has any knowledge. Original Forms M-8453 should not be sent to DOR, but must instead be retained by the ERO on the ERO's business premises for a period of three years from the date the return to which the M-8453 relates was filed.

ERO's signature and SSN or PTIN	Date	EIN	☐ Check if self-employed
	06092018	30-1017196	

Firm name (or yours, if self-employed) and address	City/Town	State	Zip	☐ Check if also paid preparer
GLOBAL TAXES LLC 2530 PEBBLE CREEK LN	CUMMING	GA	30041	

Part 4. Declaration and Signature of Paid Preparer (if other than ERO)

Under pains and penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements, and to the best of my knowledge and belief it is true, correct and complete. This declaration of paid preparer (other than taxpayer) is based on all information of which the preparer has any knowledge.

Paid preparer's signature and SSN or PTIN	Date	EIN	☐ Check if self-employed
P02090332	06092018	30-1017196	

Firm name (or yours, if self-employed) and address	City/Town	State	Zip
APPANA RUPA VENKATA SATYA SAI MANI KUMAR 2530 PEBBLE CREEK LN	CUMMING	GA	30041

2017 Form 1

MA17001011555

Massachusetts Resident Income Tax Return

FOR FULL YEAR RESIDENTS ONLY

For the year January 1–December 31, 2017 or other taxable

Year beginning Ending

LAKSHMI SUNANDA ALLURI 859-11-6062

63 GOODWIN DR NORTH BRUNSWICK NJ 08902

Fill in if: X Original return Amended return Amended return due to federal change Apt. no.

State Election Campaign Fund: $1 You $1 Spouse TOTAL 0

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

Taxpayer deceased You Spouse

Fill in if under age 18 You Spouse

a. Total federal income 36488

b. Federal adjusted gross income 35488

Name/address changed since 2016

Fill in if noncustodial parent

Fill in if filing Schedule TDS

1. Filing status (select one only)**:** X Single

Married filing jointly

Married filing separate return

Head of household You are a custodial parent who has released claim to exemption for child(ren)

2. Exemptions

a. Personal exemptions		**2a**	4400
b. Number of dependents. (Do not include yourself or your spouse.) Enter number		× $1,000 = **2b**	0
c. Age 65 or over before 2018	You + Spouse =	× $700 = **2c**	0
d. Blindness	You + Spouse =	× $2,200 = **2d**	0
e. Medical/dental		**2e**	0
f. Adoption		**2f**	0
g. Total exemptions. Add lines 2a through 2f. Enter here and on line 18		**2g**	4400

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

PRIVACY ACT NOTICE AVAILABLE UPON REQUEST

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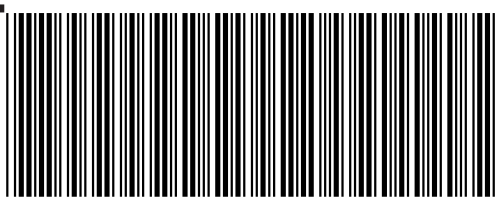
MA17001021555

Massachusetts Resident Income Tax Return

859-11-6062

3.	Wages, salaries, tips	**3**		36488
4.	Taxable pensions and annuities	**4**		0
5.	Mass. bank interest: a. 0 – b. exemption 0	= **5**		0
6.	Business/profession income/loss a. 0 + b. Farming income/loss 0	= **6**		0
7.	Rental, royalty and REMIC, partnership, S corp., trust income/loss	**7**		0
8a.	Unemployment	**8a**		0
8b.	Mass. lottery winnings	**8b**		0
9.	Other income from Schedule X, line 5	**9**		0
10.	**TOTAL 5.1% INCOME**	**10**		36488
11a.	Amount paid to Soc. Sec. Medicare, R.R., U.S. or Mass. Retirement	**11a**		0
11b.	Amount your spouse paid to Soc. Sec., Medicare, R.R., U.S. or Mass. Retirement	**11b**		0
12.	Child under age 13, or disabled dependent/spouse care expenses	**12**		0
13.	Number of dependent member(s) of household under age 12, or dependents age 65 or over (not you or your spouse) as of 12/31/17, or disabled dependent(s) **Not more than two.** a.	× $3,600 = **13**		0
14.	Rental deduction. a. 0	÷ 2 = **14**		0
15.	Other deductions from Schedule Y, line 19	**15**		1000
16.	**Total deductions.** Add lines 11 through 15	**16**		1000
17.	**5.1% INCOME AFTER DEDUCTIONS.** Subtract line 16 from line 10. **Not less than "0"**	**17**		35488
18.	Exemption amount	**18**		4400
19.	**5.1% INCOME AFTER EXEMPTIONS.** Subtract line 18 from line 17. **Not less than "0"**	**19**		31088
20.	**INTEREST AND DIVIDEND INCOME**	**20**		0
21.	**TOTAL TAXABLE 5.1% INCOME.** Add lines 19 and 20	**21**		31088

BE SURE TO INCLUDE THIS PAGE WITH FORM 1, PAGE 1



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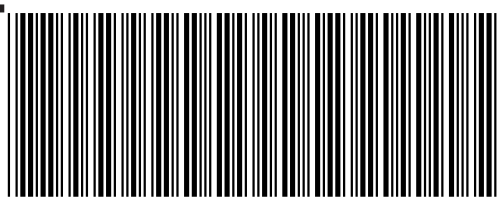
MA17001031555

Massachusetts Resident Income Tax Return

859-11-6062

22.	**TAX ON 5.1% INCOME**. **Note:** If choosing the optional 5.85% tax rate, fill in and multiply line 21 and the amount in Schedule D, line 21 by .0585		**22**	1585
23.	**12% INCOME.** Not less than "0." a. 0	× .12 =	**23**	0
24.	**TAX ON LONG-TERM CAPITAL GAINS. Not less than "0."** Fill in if filing Schedule D-IS		**24**	0
	Fill in if any excess exemptions were used in calculating lines 20, 23 or 24			
25.	Credit recapture amount (from Credit Recapture Schedule)		**25**	0
26.	Additional tax on installment sale		**26**	0
27.	If you qualify for No Tax Status, fill in and enter "0" on line 28			
28.	**TOTAL INCOME TAX.** Add lines 22 through 26		**28**	1585
29.	Limited Income Credit		**29**	0
30.	Income tax due to another state or jurisdiction		**30**	0
31.	Other credits from Credit Manager Schedule		**31**	0
32.	**INCOME TAX AFTER CREDITS.** Subtract the total of lines 29 through 31 from line 28. **Not less than "0"**		**32**	1585
33.	**Voluntary Contributions**			
	a. Endangered Wildlife Conservation		**33a**	0
	b. Organ Transplant Fund		**33b**	0
	c. Massachusetts AIDS Fund		**33c**	0
	d. Massachusetts U.S. Olympic Fund		**33d**	0
	e. Massachusetts Military Family Relief Fund		**33e**	0
	f. Homeless Animal Prevention and Care		**33f**	0
	Total. Add lines 33a through 33f		**33**	0
34.	Use tax due on Internet, mail order and other out-of-state purchases		**34**	0
35.	Health care penalty a. You 0 + b. Spouse 0 – c. Fed. health care penalty	0	**35**	0
36.	**INCOME TAX AFTER CREDITS PLUS CONTRIBUTIONS AND USE TAX.** Add lines 32 through 35		**36**	1585



2017 Form 1, pg. 4

MA17001041555

Massachusetts Resident Income Tax Return

859-11-6062

37.	Massachusetts income tax withheld	**37**		1861
38.	2016 overpayment applied to your 2017 estimated tax	**38**		0
39.	2017 Massachusetts estimated tax payments	**39**		0
40.	Payments made with extension	**40**		0
41.	Payments made with original return	**41**		0
42.	Earned Income Credit. a. Number of qualifying children Amount from U.S. return 0 × .23 =	**42**		0
	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 if you qualify for this exception			
43.	Senior Circuit Breaker Credit	**43**		0
44.	Other Refundable Credits	**44**		0
45.	**TOTAL.** Add lines 37 through 44	**45**		1861
46.	**Overpayment.** Subtract line 36 from line 45	**46**		276
47.	Amount of overpayment you want **applied to your 2018 estimated tax**	**47**		0
48.	**Refund.** Subtract line 47 from line 46. Mail to: Massachusetts DOR, PO Box 7001, Boston, MA 02204	**48**		276

Direct deposit of refund. Type of account X checking savings

RTN # 081000032 account # 355004274736

49.	**Tax due. Pay online at www.mass.gov/dor/payonline.** Mail to: Mass. DOR, PO Box 7002, Boston, MA 02204	**49**		0
	Interest 0 Penalty 0 M-2210 amt. 0		EX enclose Form M-2210	

May the Department of Revenue discuss this return with the preparer shown here? Yes

I do not want preparer to file my return electronically (this may delay your refund)

Print paid preparer's name: APPANA RUPA VENKATA SATYA SAI MANI KUMA

Date: 06092018 Check if self-employed

Paid preparer's SSN/PTIN: P02090332

Paid preparer's signature: APPANA RUPA VENKATA

Paid preparer's phone: 678-965-9729

Paid preparer's EIN: 30-1017196

BE SURE TO INCLUDE THIS PAGE WITH FORM 1, PAGE 1

2017 Schedule X & Y

MA17SXY011555

LAKSHMI SUNANDA ALLURI 859-11-6062

Schedule X. Other Income

1.	Alimony received	**1**	0
2.	Taxable IRA/Keogh and Roth IRA conversion distributions	**2**	0
3.	Other gambling winnings. **Not less than "0."** Certain gambling losses are deductible under Massachusetts law	**3**	0
4.	Fees and other 5.1% income. **Not less than "0"**	**4**	0
5.	Total other 5.1% income. Add lines 1 through 4. **Not less than "0"**	**5**	0

Schedule Y. Other Deductions

1.	Allowable employee business expenses	**1**	0
2.	Penalty on early savings withdrawal	**2**	0
3.	Alimony paid	**3**	0
4.	Amounts excludible under MGL Ch. 41, sec. 111F or U.S. tax treaty incl. in Form 1, line 3 or Form 1-NR/PY, line 5	**4**	0
	Income received by a firefighter or police officer incapacitated in the line of duty, per MGL Ch. 41, sec. 111F		
	Income exempt under U.S. tax treaty		
5.	Moving expenses	**5**	1000
6.	Medical savings account deduction	**6**	0
7.	Self-employed health insurance deduction	**7**	0
8.	Health care accounts deduction	**8**	0
9.	Certain qualified deductions from U.S. Form 1040		
	Certain business expenses from U.S. Form 1040	**9**	0
10.	Student loan interest	**10**	0
11.	College Tuition Deduction	**11**	0
12.	Undergraduate student loan interest deduction	**12**	0
13.	Deductible amount of qualified contributory pension income from another state or political subdivision included in Form 1, line 4 or Form 1-NR/PY, line 6	**13**	0
14.	Claim of right deduction	**14**	0
15.	Commuter deduction	**15**	0
16.	Human organ donation deduction (full-year residents only)	**16**	0
17.	Certain gambling losses	**17**	0
18.	Prepaid tuition or college savings program deduction	**18**	0
19.	Total other deductions. Add lines 1 through 18	**19**	1000

2017 Schedule INC
MA17INC011555

LAKSHMI SUNANDA ALLURI 859-11-6062

Form W-2 and 1099 Information

A. FEDERAL ID NUMBER	B. STATE TAX WITHHELD	C. STATE WAGES/INCOME	D. TAXPAYER SS WITHHELD	E. SPOUSE SS WITHHELD	F. SOURCE OF WITHHOLDING
20-4346137	1861	36488	0	0	W2
TOTALS	1861	36488	0	0	

2017 Schedule HC

MA17029011555

Schedule HC, Health Care Information, must be completed by all full-year residents and certain part-year residents (see instructions). **Note:** Schedule HC must be enclosed with your Form 1 or Form 1-NR/PY. Failure to do so will delay the processing of your return.

LAKSHMI SUNANDA ALLURI 859-11-6062

1a. Date of birth 05211992 **1b.** Spouse's date of birth **1c.** Family size 1

2. Federal adjusted gross income **2** 35488

3. Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. **Note:** MassHealth, Medicare, and health coverage for U.S. Military, including Veterans Administration and Tri-Care, meet the MCC requirements. If you did not receive a Form MA 1099-HC from your insurer, or you had insurance that did not meet MCC requirements, see the special section on MCC requirements in the instructions.

See instructions if, during 2017, you turned 18, you were a part-year resident or a taxpayer was deceased.

3a You:	X Full-year MCC	Part-year MCC	No MCC/None
3b Spouse:	Full-year MCC	Part-year MCC	No MCC/None

If you filled in the full-year or part-year MCC oval, 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, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, fill in line(s) 4f and/or 4g and see instructions. Fill in if you were enrolled in private insurance and MassHealth or Commonwealth Care and enter your private insurance information in line(s) 4f and/or 4g and go to line 5.

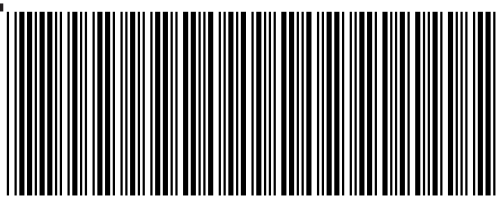
4a. Private insurance, including ConnectorCare (completes line(s) 4f and/or 4g below)		You	Spouse
4b. MassHealth. Fill in and go to line 5	X	You	Spouse
4c. Medicare (including a replacement or supplemental plan). Fill in and go to line 5		You	Spouse
4d. U.S. Military (including Veterans Administration and Tri-Care). Fill in and go to line 5		You	Spouse
4e. Other government program (enter the program name(s) only in lines 4f and/or 4g below). **Note:** Health Safety Net is not considered insurance or minimum creditable coverage.		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.

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.

5. If you had health insurance that met MCC requirements for the full-year, including private insurance, MassHealth, Commonwealth Care or ConnectorCare, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. Otherwise, go to line 6.

If you had Medicare (including a replacement or supplemental plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance at any point during 2017, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. Otherwise, go to line 6.



2017 Schedule HC, pg. 2

859-11-6062 MA17029021555

Uninsured for All or Part of 2017

6. Was your income in 2017 at or below 150% of the federal poverty level? **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 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 below the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in 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 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

You	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
Spouse	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.

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 months in a row), go to line 8a. Otherwise, a penalty does not apply to you in 2017. Skip the remainder of this schedule and complete your tax return.

Religious Exemption and Certificate of Exemption

8a. **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.

8b. 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, skip the remainder of this schedule and continue completing your tax return. If you answer Yes to line 8b, go to line 9.

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

If you answer Yes, enter the certificate number, skip the remainder of this schedule and continue completing your tax return. If you answer No to line 9, go to line 10.

2017 Schedule HC, pg. 3

MA17029031555

LAKSHMI SUNANDA ALLURI 859-11-6062

Affordability as Determined By State Guidelines

Note: This section will require the use of worksheets and tables found in the instructions. 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 minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10 in the instructions?	10 You	Yes	No
	Spouse	Yes	No

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

11. Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11 in the instructions?	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 in the instructions to calculate your penalty amount.

12. Were you able to purchase affordable private health insurance that met minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12 in the instructions?	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 in the instructions to calculate your penalty amount.

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 meets 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 field(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the field 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. **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 your original 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.

Schedule HC Worksheet **LAKSHMI SUNANDA's Schedule HC Worksheet** **2017**

► Keep for your records

Name(s) Shown on Return	Social Security Number
LAKSHMI SUNANDA ALLURI	859-11-6062

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. (See the special section on MCC requirements in the instructions.)

[X] Full-year MCC [ ] Part-year MCC [ ] No MCC/None

4 Indicate the health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements in which you were enrolled in 2017, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, check line(s) 4f and/or 4g and see instructions. Check if you were enrolled in private insurance and MassHealth, and enter your private insurance information in Your Health Insurance Smartworksheet.

a	Private Insurance (including connector care)	You	[ ]
b	MassHealth	You	[X]
c	Medicare	You	[ ]
d	U.S. Military (including Veterans Administration and Tri-Care)	You	[ ]
e	Other government program (enter the program name(s) only below	You	[ ]

Name of Insurance Carrier or Program

4 f Check if you were not issued Form MA 1099-HC [ ]

Your Health Insurance Smart Worksheet

Name of Insurance Company or Administrator (from Form MA 1099-HC)	Federal Identification No. of Insurance Company (from Form MA 1099-HC)	Subscriber No. (from Form MA 1099-HC)

7 Complete this section **only** if you and/or your spouse if MFJ, were enrolled in a health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements for part, but not all of 2017. Check the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, check the months you were covered by a plan that met the MCC requirements at least **15 days or more.** See instructions if, during 2017, you **turned 18,** you were a **part-year resident** or a taxpayer was **deceased.**

Special Circumstance Instructions

[ ] Indicates special circumstances

Check the month(s) you were alive, age 18, or a resident of Massachusetts for 2017

[ ] Jan	[ ] Feb	[ ] March	[ ] April	[ ] May	[ ] June
[ ] July	[ ] Aug	[ ] Sept	[ ] Oct	[ ] Nov	[ ] Dec

Months Covered By Health Insurance That Met Minimum Creditable Coverage

You should only check the month(s) you had health insurance that met MCC requirements.

[ ] Jan	[ ] Feb	[ ] March	[ ] April	[ ] May	[ ] June
[ ] July	[ ] Aug	[ ] Sept	[ ] Oct	[ ] Nov	[ ] Dec

Religious Exemption and Certificate of Exemption

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? . . . . . ► Yes ☐ No ☐

If you answer Yes, go to line 8b. If you answer No, go to line 9.

8 b If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2017 tax year? . . . . . ► Yes ☐ No ☐

If you answer No to line 8b, skip the remainder of this schedule and continue completing your tax return. If you answer Yes to line 8b, go to line 9.

9 **Certificate of exemption**: Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2017 tax year? . . . . . ► Yes ☐ No ☐

If you answer Yes enter the certificate number, skip the remainder of this schedule and continue completing your tax return. If you answer No to line 9, go to line 10.

Certificate No.

Schedule HC Worksheet for Line 10

Did your employer (or your spouse's employer if married filing jointly) offer you health insurance?	☐ Yes	☐ No
If you answered "Yes" above, was this insurance free?	☐ Yes	☐ No

The following worksheet will determine if you could have afforded employer-sponsored health insurance that met Minimum Creditable Coverage in 2017. Complete only if you (and/or your spouse if married filing jointly) were eligible for insurance that met Minimum Creditable Coverage offered by an employer for the entire period you were uninsured in 2017 that covered you, and your spouse and dependent children, if any. If an employer did not offer health insurance that met Minimum Creditable Coverage that covered you, and your spouse and dependent children, if any, or if you were not eligible for insurance that met Minimum Creditable Coverage offered by an employer, you were self employed or you were unemployed, check the No box on line 10 and complete the Schedule HC Worksheet for line 11.

Note: If line 6 of the Schedule HC is checked Yes indicating that your income was at or below 150% of the federal poverty level or you had three or fewer blanks in a row during the period that the mandate applied on line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. If an employer offered you free health insurance coverage in 2017 that met Minimum Creditable Coverage (the employer's Human Resources Department should be able to provide this information to you), you are deemed able to afford health insurance and are subject to a penalty. Check the Yes box in line 10 and go to the Health Care Penalty Worksheet.

1	Enter your federal adjusted gross income (from U.S. Form 1040, line 37, Form 1040A, line 21 or Form 1040EZ, line 4)	**1**	

If line 1 is less than or equal to:

- ► $17,820 if single or married filing a separate with no dependents;
- ► $24,030 if married filing jointly with no dependents or head of household/married filing separately with one dependent; or
- ► $30,240 if married filing jointly with one or more dependents or head of household/married filing separately with two or more dependents,

you are deemed unable to afford employer-sponsored health insurance that met Minimum Creditable Coverage requiring an employee contribtuion. Check the No box in line 10. Skip the remainder of this worksheet and go to the Schedule HC Worksheet for Line 11.

If line 1 is more than:

- ► $17,820 if single or married filing separately with no dependents;
- ► $24,030 if married filing jointly with no dependents or head of household/married filing separately with one dependent; or
- ► $30,240 if married filing jointly with one or more dependents or head of household/married filing separately with two or more dependents, **go to line 2.**

2	Enter the lowest monthly premium cost of health insurance that would cover you, and your spouse and dependent children, if any, offered to you during your uninsured period in 2017 through an employer. The employer's Human Resources Department should be able to provide this amount to you	**2**	

Note: If you declined employer-sponsored health insurance that met the Minimum Creditable Coverage, the monthly premium amount may be found on the Health Insurance Responsibility Disclosure Form (HIRD) you should have received from your employer.

3	Enter the monthly premium that as a percentage of income that corresponds with your income range (from line 1 of worksheet and filing status from Table 3: Affordability from the instructions	**3**	
4	Multiply 1 by line 3	**4**	
5	Divide line 4 by 12 to calculate the monthly premium considered affordable to you	**5**	

If line 2 is less than or equal to line 5:

you are deemed able to afford employer-sponsored health insurance that met Minimum Creditable Coverage during your uninsured period(s), which you did not obtain, and you are subject to a penalty. Fill in the Yes oval(s) in line 10 of Schedule HC, and go to the Health Care Penalty Worksheet on page HC-11.

If line 2 is greater than line 5:

you could not afford health insurance that met Minimum Creditable Coverage offered to you by your employer, fill in the No oval(s) in line 10 of Schedule HC, and complete the following Schedule HC Worksheet for Line 11 on page HC-8.

Schedule HC Worksheet for Line 11: Eligibility for Government-Subsidized Health Insurance

Line 11: Eligibility for Government-Subsidized Health Insurance Smart Worksheet

A In 2017, were any of these statements true?

- ► I was not a citizen or a non-citizen legally residing in the U.S.,
- ► An employer offered an individual plan that cost less than 9.69% of your household income and met minimum value standards (the employer's Human Resource Department should be able to provide this information to you),
- ► I applied for Mass Health or subsidized coverage through the Health Connector and were denied because I was inelegible for services

Are any of the statements in A true? . . . . . ☐ No ☐ Yes

The following worksheet will determine if you were eligible for government-subsidized health insurance in 2017. Complete the following worksheet only if an employer did not offer you affordable health insurance that met Minimum Creditable Coverage requirements, as determined in the Schedule HC Worksheet for Line 10.

Note: If line 6 of the Schedule HC is checked Yes indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blanks in a row on line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return.

If married filing separately **and** living in the same household, each spouse must combine their income figures from their separate U.S. returns when completing this worksheet.

1	Enter your federal adjusted gross income (from U.S. Form 1040, line 37, Form 1040A, line 21 or Form 1040EZ, line 4)	**1**	
2	Enter the amount from the Income column, based on your family size (do not include dependent children age 19 or older in your family size), from Table 2 in the instructions	**2**	

If line 1 is greater than line 2:

you were ineligible for government-subsidized health insurance in 2017 and must fill in the No oval(s) in line 11 of Sched ule HC, and go to Schedule HC Worksheet for Line 12 to determine if you were deemed able to afford private health insurance.

If line 1 is less than or equal to line 2, and at any point during the period when you were uninsured:

- ► you were not a citizen or a non-citizen legally residing in the U.S., **or**
- ► an employer offered an individual plan that cost less than 9.69% of your household income (the employer's Human Resources Department should be able to provide this information to you) **or**
- ► you applied for Mass Health or subsidized coverage through the Health Connector and were denied because you were ineligible for services,

you are deemed ineligible for government-subsidized health insurance in 2017 .

Fill in the No oval(s) in line 11 of Schedule HC, and go to Schedule HC Worksheet for Line 12 to determine if you were able to afford private health insurance.

If line 1 is less than or equal to line 2 and none of the conditions above apply, then

- ► you would have been deemed eligible for government-subsidized health insurance in 2017 which you did not obtain and you are subject to a penalty. You must
- ► check the Yes box in line 11, **and** go to the Health Care Penalty Worksheet.

Note: If you believe that during the period when you were unisured, your income was actually too high to qualify for government-subsidized insurance, you may have grounds to appeal the penalty. Check the Yes box in line 11 and go to the instructions for the Appeals section on schedule HC.

Schedule HC Worksheet for Line 12: Ability to Purchase Affordable Private Health Insurance That Met Minimum Creditable Coverage

The following worksheet will determine if you could have purchased affordable private health insurance that met Minimum Creditable Coverage in 2017. Complete the following worksheet only if you (and/or your spouse if married filing jointly) were deemed ineligible for government-subsidized health insurance, as determined in the Schedule HC Worksheet for Line 11.

Note: If line 6 of the Schedule HC is checked Yes indicating that your income was at or below 150% of the Federal Poverty Level or you had three or fewer blanks in a row on line 7 of Schedule HC, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return. Schedule HC must be attached to your return.

1	Enter your federal adjusted gross income (from U.S. Form 1040, line 37, Form 1040A, line 21 or Form 1040EZ, line 4)	**1**	
2	Enter the monthly premium that corresponds with your county of residency (see the printed government instructions if you do not know what county you live in), age (if married filing a joint return, use the age of the older spouse) and filing status from Table 4: Premiums on page HC-10 from the instructions	**2**	
3	Enter the affordable premium as a percentage of income that corresponds with your income range (from line 1 of worksheet) and filing status from Table 3: Affordability on page HC-10 from the instructions	**3**	
4	Multiply 1 by line 3	**4**	
5	Divide line 4 by 12 to calculate the monthly premium considered affordable to you	**5**	

If line 2 is greater than line 5:

you are deemed unable to afford health insurance that met Minimum Creditable Coverage and not subject to a penalty, and you must fill in the No oval(s) in line 12 of Schedule HC and skip the remainder of Schedule HC and continue completing your tax return.

If line 2 is less than or equal to line 5:

you are deemed able to afford private health insurance that met Minimum Creditable Coverage, which you did not obtain; you are subject to a penalty and you must fill in the Yes oval(s) in line 12 of Schedule HC and go to the Health Care Penalty Worksheet on page HC-11.

Schedule HC Worksheet - Penalty Worksheet

Complete the following worksheet to calculate the penalty. If married filing a joint return and both you and your spouse are subject to a penalty, separate worksheets must be filled out to calculate the separate penalty amounts for you and your spouse, using your married filing jointly income. Each separate penalty amount must then be entered on Form 1, line 34a and line 34b or Form 1-NR/PY, line 39a and line 39b.

Note: If line 6 is checked of the Schedule HC is checked Yes indicating that your income was at or below 150% of the Federal Poverty Level, the penalty does not apply to you. Do not complete this worksheet. Skip the remainder of Schedule HC and continue completing your return.

1	Enter your federal adjusted gross income from line 2 of Schedule HC	**1**	
3	Based on Family Size, federal AGI and your age calculated penalty	**3**	
4	How many gap(s) in coverage of four or more consececutive months do you have in Schedule HC, line 7? If you were uninsured for all of 2017 enter "0"	**4**	0
	► ***Turning 18, Part-Year Residents or a Taxpayer was deceased .*** When completing line 4, do not include the number of unfilled checkboxes for months that the mandate did not apply, as determined in Schedule HC, line 7.		
5	Enter the total number of months for the gap(s) in coverage as identified in line 4. Enter "12" if you were uninsured for all of 2017.	**5**	
	► ***ATTENTION: Taxpayer, or Spouse if married filing jointly, was deceased or Turned 18 or a Part-Year Resident. See Government Instructions Sch. HC.***		
6	Multiply line 4 by "3"	**6**	0
7	Subtract line 6 from line 5	**7**	0
8	Multiply line 3 by line 7. This is the penalty amount for you	**8**	0

If you are subject to a penalty because you are deemed able to afford insurance in 2017 but did not obtain it, you may appeal the application of the penalty to you. Go to the Filing an Appeal section on the Schedule HC and follow these instructions. If you are filing an appeal, do not enter a penalty amount on Form 1, line 34a or line 34b or Form 1-NR/PY, line 39a and line 39b. If you are **not** appealing the penalty, enter the penalty amount from line 8 on Form 1, line 34a or 34b or Form 1-NR/PY, line 39a and line 39b.

Complete Only If You Are Filing An Appeal

You:

☐ I wish to appeal the penalty. I authorize DOR to share my tax return including this schedule with the Commonwealth Health Insurance Connector Authority for purposes of deciding my appeal.

Massachusetts Information Worksheet 2017

► Keep for your personal records

Part I — Personal Information

Taxpayer:

First Name . . . . . LAKSHMI SUNANDA
Middle Initial . . . . . Suffix . . . .
Last Name . . . . . ALLURI
Social Security No. . 859-11-6062
Occupation SOFTWARE ENGINEER
Date of Birth 05/21/1992
Date of Death . . . .
Daytime Phone . . .
Home Phone . . . .

Spouse:

First Name . . . . . .
Middle Initial . . . . . Suffix . . . .
Last Name . . . . . .
Social Security No. . .
Occupation
Date of Birth . . . . .
Date of Death. . . . .
Daytime Phone . . . .
Use home phone for spouse . . . . . .

Print phone number on vouchers ☐ TP work ☐ TP home ☐ Spouse work ☐ Spouse home

Address . . . . . 63 GOODWIN DR Apt . . . . .
City . . . . . NORTH BRUNSWICK State . . NJ ZIP Code . 08902
In care of Address .
City . . . . . State . . ZIP Code .
Foreign state . . Foreign country . Foreign Postal Code

Part II — Main Form

☒ Form 1: Resident Tax Return . . . . . ►
☐ Form 1-NR/PY: Nonresident Return . . . . . ►
☐ Form 1-NR/PY: Nonresident and Part-Year Resident Return (**Sch R/NR**) . . . . . ►
☐ Form 1-NR/PY: Part-year Resident Return . . . . . ►

Residency dates . . . . . From To

Part III — Filing Status

☒ Single
☐ Married filing joint return
☐ Married filing separate return
☐ Head of household

Spouse federal Total Income *(If MFS and living together)* . . . . . .
Spouse federal AGI *(If MFS and living together)* . . . . . .
Total dependents claimed *(If MFS and living together)* . . . . . .

☐ Check here if the taxpayer is a victim of domestic abuse, is married filing separate and wants to claim EITC

If claiming exception above. Amount of EIC as calculated from EIC Worksheet 0
If claiming exception above. Number of qualifying children used to calculate EIC 0

Part IV — Dependent Information

Full Name	Relationship	Age	Disabled?
			☐
			☐
			☐
			☐

Part V — Electronic Filing Information

New! State e-file disclosure consent:

By using a computer and software to prepare and transmit my client's return electronically, I consent to the disclosure of all information pertaining to my use of the system and software to create my client's return and to the electronic transmission of my client's tax return to the Massachusetts Department of Revenue, as applicable by the law.

☒ State return will be filed electronically
☐ Tax return was prepared by taxpayer or other non-paid preparer

Enter the date return was EFiled . . . . . ►
Enter the date return was accepted by the state . . . . . ►
Enter the date Form PV was given to client . . . . . .
QuickZoom to Form M-8453 Additional Information SmartWorksheet . . . . . ►

Part VI — Direct Deposit Information or Electronic Funds Withdrawal Information

Yes	No	
		Do you want **electronic funds withdrawal** of **state tax payment** (Electronic Filing Only)?
X		Do you want to elect **direct deposit** of **state tax refund**?
		Extension - Do you want **electronic funds withdrawal** of **tax due** (Electronic Filing Only)?

If you selected direct deposit or electronic funds withdrawal, fill out the information below:

Name of Financial Institution (optional) . . . . . ► BANK OF AMERICA

Check the appropriate box:

Checking . . . . . ► X

Savings . . . . . ►

Routing number . . . . . ► 081000032

Account number . ► 355004274736

International ACH Transactions

Yes	No	
	X	Will the funds for this refund (or payment) go to (or come from) an account outside the U.S.?

Additional information for electronic funds withdrawal:

Electronic funds withdrawal amount due with **return** information (*Electronic Filing Only):*

Enter the payment date to withdraw from the account above . . . . . _____

State balance-due amount from this return . . . . . _____

Electronic funds withdrawal amount due with **extension** information (*Electronic Filing Only)*

Enter settlement date to withdraw the extension amount from the account above . . . . . _____

State balance-due amount paid with this extension Form M-4868 . . . . . _____

Part VII — Additional Return Information

1 State Election Campaign Fund:

- ☐ TP wants $1 to go to Massachusetts Election Campaign Fund
- ☐ Spouse wants $1 to go to Massachusetts Election Campaign Fund

2 Non-Custodial Parent:

- ☐ Non-custodial parent

3 Schedule TDS:

- ☐ Filing Schedule TDS

4 First Time Filer:

- ☐ First time filer with Massachusetts Department of Revenue

5 Address/Name Change:

- ☐ Name or address changed since 2016

6 Farmer and Fisherman Status:

- ☐ Farmer and fisherman

7 Rental Deduction/Circuit Breaker Credit:

Rent paid in Massachusetts during 2017 . . . . _____

a Senior Circuit Breaker Credit:

- ☐ Living in Public or Subsidized housing.

8 Payments to Retirement Systems made during 2017:	**Taxpayer**	**Spouse**
a Social security and medicare tax withholding		
b Federal self-employment tax		
c Massachusetts retirement systems (including political subdivisions)		
d U.S. retirement systems (other than social security, medicare, self-employment and railroad retirement included in lines a or b) . . .		
e Total payments to retirement systems		

9 Wages Taxed by More Than One State (Massachusetts Resident)

- ☐ Exclude **Non-Massachusetts wages** from Form 1 (see Tax Help)

10 Form EFO:

- ☐ Print Massachusetts Form EFO
- ☐ Not required to file Massachusetts Form EFO

Part VIII — Preparer Information

Enter Preparer Code from Firm/Preparer Info . . . 1

Yes	No	
☐	☐	May Department of Revenue discuss return with preparer?

Part IX — Extension Status

Yes	No	
☐	☒	Tax return due date extended?

Extended due date . . . _____

☐ First extension will be filed electronically (Form M-4868)

Filing and Acceptance Information (Electronic Filing Only):

☐ Extension accepted

Extension filing date . . . . . _____

Extension acceptance date . . . . . _____

QuickZoom to Form M-4868: Automatic Six-Month Extension of Time To File Income Tax . . . . . ► _____

QuickZoom to Form 1 . . . . . ► _____

QuickZoom to Form 1-NR/PY . . . . . ► _____

Tax Payments Worksheet 2017

► Keep for your records

Name	Social Security Number
LAKSHMI SUNANDA ALLURI	859-11-6062

Tax Payments for the Current Year

		State	
		Date	Payment
1	First Payment		
2	Second Payment		
3	Third Payment		
4	Fourth Payment		
	Additional Payments		
5	Payment		
	Payment		
	Payment		
	Payment		
	Payment		

6	Overpayment from previous year applied to current year	6	
7	Amount paid with current year extension	7	
8	**Total tax payments**	8	

Income Taxes Withheld for the Current Year

9	State withholding on Forms W-2	9	1,861.
10	State withholding on Forms W-2G	10	
11	State withholding on Forms 1099-R	11	
12 a	State withholding on Forms 1099-MISC	12 a	
b	State withholding on Forms 1099-G	b	
c	State withholding on Forms 1099-K	c	
13	Other state tax withholding	13	
14	**Total income tax withheld**	14	1,861.
15	Date return will be filed and balance paid	15	

Smart Worksheets from your 2017 Massachusetts Tax Return

SMART WORKSHEET FOR: Individual Income Tax Declaration for Electronic Filing

Additional Information Smart Worksheet

A	Date this return was E-Filed	►
B	Date return was accepted by the state	►

C Documents to attach to the FRONT of Form M-8453:

Form W-2 (Copy 2)

D **Retain Form M-8453 and all attachments for a period of three years**
DO NOT MAIL TO STATE AUTHORITIES

SMART WORKSHEET FOR: Form 1: Resident Tax Return

Calculation of overpayment or balance due including interest, penalty and underpayment penalty

Net refund including interest, penalty and underpayment penalty, if any	►	276
Total balance due including interest, penalty and underpayment penalty, if any	►	0

SMART WORKSHEET FOR: Schedule X and Y: Other Income and Other Deductions

Schedule Y Deductions Smart Worksheet

		Federal Amount	MA Amount
A	Moving expenses	1000	1000
B	Medical savings account deduction		
C	Self-employed health insurance deduction		
D	Health care accounts deduction		
E	Certain qualified deductions from U.S. Form 1040		
F	Certain business expenses from U.S. Form 1040		
G	Student loan interest deduction		
H	Jury duty pay you gave to your employer		
I	MSRRA Excluded Wages		
J	MSRRA Excluded Personal Service Income		

SMART WORKSHEET FOR: Schedule HC: Health Care Information

Family Size Smart Worksheet

A	Taxpayer	1
B	Spouse	
C	Dependents	
D	Spouse federal AGI(*If MFS and lived together*)	