Emshwiller/Scheer Accountancy Co., Inc. d/b/a
EMSHWILLER and EMSHWILLER
Phone 260-824-1826 / www.emshwiller.net
207 N. Johnson St., Bluffton, Indiana 46714

PERSONAL DATA WORKSHEET

Year _____

Name	Date of Birth	Spouse's Name	Date of Birth
Social Security Number		Social Security Number	
Address			Zip Code
County of Residence – January 1, 20___		County of Residence – January 1, 20___	
County of Employment – January 1, 20___		County of Employment – January 1, 20___	
School District		Presidential campaign Fund? Yes No	
Home Telephone Number		Work Telephone Number	
E-Mail Address		Are you being claimed as a dependent on another tax return? Yes__ No __	

( ) Single ( ) Married - Joint ( ) Married Separate ( ) Head of Household ( )Surviving Widow(er) with Child

DEPENDENTS

Dependents (1) Name (first, initial, and last name)	(2) Date of Birth	(3) Dependent's Social Security Number	(4) Relationship	(5) No. of months lived in your home in 20___

If your child didn't live with you but is claimed as your dependent under a pre-1985 agreement, check here _____

INCOME FROM WAGES (W-2) OR GAMBLING (W-2G)

T/S	Name of Employer	Gross	Fed. W/H	Soc. Sec.	Med W/H	IN State W/H	IN Local Tax

PENSION / IRA DISTRIBUTION

T/S	Name of Employer	Gross	Fed. W/H	IN State W/H	IN Local Tax		

INTEREST (I) AND/OR DIVIDEND (D) INCOME

T/S	I / D	Source	Amount	T/S	I / D	Source	Amount

OTHER INCOME AND INFORMATION

T/S	Source	Amount	T/S	Source	Amount
	Social Security Income - Taxpayer			Unemployment Compensation	
	Social Security Income - Spouse			State Tax Refund	

CAPITAL GAINS AND LOSSES - Please provide cost basis statement.

Description/Number of Shares	Date Acquired	Date Sold	Sales Price	Cost Basis

ESTIMATED TAX PAYMENTS

Due Date: (Estimated Fed. Income Tax Paid)	4-15-20___	6-15-20___	9-15-20___	1-16-20___
Date Paid				
Amount	$	$	$	$
ESTIMATED ST. INCOME TAX PAID				
Date Paid				
Amount	$	$	$	$

ITEMIZED DEDUCTIONS

HEALTH INSURANCE

Health Insurance provided by: Employer ____ Self ____ No. of Months_____ (Provide 1095 B or C)

MEDICAL AND DENTAL

Prescription Medicines & Drugs	$		Dr.	$	
Artificial Teeth			Dr.		
Dental			Total	$	
Eyeglasses			INSURANCE REIMBURSEMENTS		
Hearing Aids & Batteries					
Hospital					
Nursing Home or Long-Term Care Fees			HOSPITAL & MEDICAL INSURANCE PREMIUMS		
Laboratory & Fees					
Nurse & Nursing					
Orthopedic Shoes – Braces					
Therapy Treatments					
Transportation Expense					
Auto Miles For Medical Treatment Miles			Long-Term Care Insurance - Taxpayer.	$	
X Rays			Long-Term Care Insurance - Spouse		
			TOTAL INSURANCE	$	

CONTRIBUTIONS

Name of Organization (need receipt if over $250.00)			$	
		Charity Auto Miles @ ¢		
		Non Cash Contributions (Date, Description, Fair Market Value)		
		Total Contributions	$	

TAXES

State Income Tax	$		Sales Tax Paid on Large Purchases	$	
Local Tax			(Motor Vehicles and Boats)		
Real Estate Tax: Personal Residence			Auto Excise Tax (License Plates)		
Real Estate Tax: Second Residence					

INTEREST

Home mortgage interest paid financial Institutions (Report deductible points on list) (Form 1098)	$		Home mortgage interest you paid to individuals	$	
			Name of Payee		
			Address		
			Social Security #		

CHILD CARE EXPENSE

	$		Amount of Rent Paid In Year $	Number of Months
Number of Children			Address	
Name of Babysitter				
Address			Landlord's Name	
			Address	
Babysitter Social Security Number / FID #				

RENT

COLLEGE

	T S
Tuition Paid: Must have 8863 and Receipts	Keough Plan
Name:	Traditional IRA
Amount: Paid out of pocket/Student Loan for Tution and Books	Roth IRA
Year In School: Freshman Sophomore Junior Senior	

RETIREMENT