Government of the District of Columbia

2023 SCHEDULE HSR
DC Health Care
Shared Responsibility

2 3 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

Your taxpayer identification number (TIN) ***and*** Date of Birth (MMDDYYYY)

Spouse's/registered domestic partner's TIN ***and*** Date of Birth (MMDDYYYY)

Your first name M.I. Last name

Spouse's/registered domestic partner's first name M.I. Last name

Mailing address (number, street and suite/apartment number if applicable)

City State Zip Code +4

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 **2023**?

- ◯ **Yes. STOP. You do not owe a health care shared responsibility payment and do not need to complete a Schedule HSR.** (***Enter zero on Line 25 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 2023?

- ◯ **Yes. Proceed to Part IV.** ***See instructions.***
- ◯ **No.**

3 Was your federal adjusted gross income below the applicable filing threshold for your filing status for 2023? *See instructions.*

- ◯ **Yes. Proceed to Part IV.** ***See instructions.***
- ◯ **No.**

4 Was your federal adjusted gross income reported on your D-40, Line 4 for 2023 equal to or less than $32,367.60

- ◯ **Yes. Proceed to Part IV.** ***See instructions.***
- ◯ **No.**

If you answered Yes to any of questions 2 - 4, enter zero on Line 25 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 2023 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 2023 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 25 of your D-40. If you answered yes to question 5 or 6, you must also complete Part III.

2 3 0 4 0 0 2 2 0 0 0 0

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. Last name			
8	First name and M.I. Last name			
9	First name and M.I. Last name			
10	First name and M.I. Last name			
11	First name and M.I. Last name			
12	First name and M.I. Last name			

PART IV Complete the applicable worksheets before completing Part IV.

Round cents to nearest dollar.

13	Enter flat dollar amount (see Worksheet A-1, Line 5 or Worksheet A-2, Line 7)	13	$ .00
14	Enter the percentage income amount (see Worksheet B-1, Line 4 or Worksheet B-2, Line 14)	14	$ .00
15	Enter the larger of Line 13 or Line 14 (If Lines 13 and 14 are the same, enter that number.)	15	$ .00
16	Enter the District Average Bronze Plan Premium (see Worksheet C-1, Line 2 or Worksheet C-2, Line 2)	16	$ .00
17	Enter the smaller of Line 15 or Line 16 here and on D-40, Line 25	17	$ .00

Government of the District of Columbia **2023** DC Health Care Shared Responsibility Worksheets

Important:
KEEP FOR YOUR RECORDS.
DO NOT FILE.

A. Flat Dollar Amount Calculation

Worksheet A-1 (No exemptions claimed)

Worksheet A-1 - Complete this worksheet if you are **not** claiming any exemptions for any month for any member of your health care shared responsibility family. **(See instructions for available exemptions and who is included in your health care shared responsibility family.)**

		Round cents to nearest dollar. If amount is zero, leave line blank.
1. Multiply $745 for each member in your health care shared responsibility family who was at least 18 years old as of December 31, 2023.	1.	.00
2. Multiply $372.50 for each member in your health care shared responsibility family who was under the age of 18 years old as of December 31, 2023.	2.	.00
3. Add Lines 1 and 2.	3.	.00
4. Maximum flat dollar amount for 2023.	4.	$2,235.00
5. Enter the smaller of Lines 3 or 4 here and on Schedule HSR, Part IV, Line 13. *(Proceed to Worksheet B-1)*	5.	.00

Worksheet A-2 (Exemptions claimed for at least one month for at least one member in your health care shared responsibility family)

Worksheet A-2 - Complete the monthly columns by placing an "X" in each month to represent any member of your health care shared responsibility family that did not have minimum essential coverage or a coverage exemption. If you are claiming an exemption for the entire year for yourself and every member of your shared responsibility family, you do not complete this section. Only complete this worksheet if you are claiming an exemption for any month for any member in your health care shared responsibility family or if you or a member of your family had only partial year minimum essential coverage, even if no other exemption is claimed.

Name	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1a. Total number of X's in a month. If 5 or more, enter 5.												
1b. Add the total number reported in Line 1a here and on Worksheet C-2, Line 1.												
2. Total number of X's in a month for members age 18 or older as of December 31, 2023.												
3. One-half the number of X's in a month for members under the age of 18 years old as of December 31, 2023.												
4. Add Lines 2 and 3 for each month.												
5. Multiply Line 4 by $745 for each month. **If $2235 or more, enter $2235.**												
6. Total the amounts for each month on Line 5.										$ .00		
7. Divide Line 6 by 12.0. This is your flat dollar amount. **Enter this amount on Schedule HSR, Part IV, Line 13.** *(Proceed to Worksheet B-1)*										$ .00		

B. Percentage Income Calculation

Worksheet B-1

Worksheet B-1 - Complete this worksheet if you completed either Worksheet A-1 or Worksheet A-2. If you completed Worksheet A-2, you must also complete Worksheet B-2.

		Round cents to nearest dollar. If amount is zero, leave line blank.
1. Enter your federal adjusted gross income reported on your D-40, Line 4 for 2023.	1.	.00
2. Enter the standard deduction amount that corresponds to the filing status that you claimed on your D-40. (See HSR instructions for amounts).	2.	.00
3. Subtract Line 2 from Line 1.	3.	.00
4. Multiply Line 3 by 2.5% (0.025). This is your percentage of income amount. **Enter this amount on Schedule HSR, Part IV, Line 14 If you completed Worksheet A-1, and proceed to Worksheet C-1.** (If you were required to complete Worksheet A-2, you must proceed to Worksheet B-2 to calculate your percentage of income amount. Do not enter this amount on Schedule HSR, Part IV, Line 14.	4.	.00

Worksheet B-2 (Exemptions claimed for at least one month for at least one member in your health care shared responsibility family)

Worksheet B-2 - Complete this worksheet only if you were required to complete Worksheet A-2. Do not complete this worksheet if you completed Worksheet A-1. *** If the amount on Line 1a of Worksheet A-2 is zero for any month, leave all columns of this worksheet blank for that month.**

For each month, you must determine if the amount on Line 5 of Worksheet A-2 is less than the amount on Line 4 of Worksheet B-1.	(a) Enter the amount from **Worksheet A-2, Line 5**	(b) Enter the amount from **Worksheet B-1, Line 4**	(c) Enter the larger of column (a) or column (b)
1. January			.00
2. February			.00
3. March			.00
4. April			.00
5. May			.00
6. June			.00
7. July			.00
8. August			.00
9. September			.00
10. October			.00
11. November			.00
12. December			.00
13. Add the amounts in column (c)			.00
14. Divide Line 13 by 12.0 **Enter this amount on Schedule HSR, Part IV, Line 14.** *(Proceed to Worksheet C-2.)*			.00

Important:
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C. District Average Bronze Plan Premium Calculation

Worksheet C-1 (No exemptions claimed)

Worksheet C-1 - Complete this worksheet if you completed Worksheet A-1. If **you were** required to complete Worksheet A-2, you must complete Worksheet C-2. **(See instructions on who is included in your health care shared responsibility family.)**

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

1. Enter the number of members in your health care shared responsibility family. 1.

2. Enter the amount that corresponds to the number of members in your health care shared responsibility family.

- 1 person - $4,056
- 2 persons - $8,112
- 3 persons - $12,168
- 4 persons - $16,224
- 5 or more persons - $20,280

Enter this amount on Schedule HSR, Part IV, Line 16. 2. .00

Worksheet C-2 (Exemptions claimed for at least one month for at least one member in your health care shared responsibility family)

Worksheet C-2 - Complete this worksheet only if you were required to complete Worksheet A-2. If **you were not** required to complete Worksheet A-2, complete Worksheet C-1. Do not complete this worksheet if you completed Worksheet A-1. **(See instructions on who is included in your health care shared responsibility family.)**

1. Enter the total number reported on Worksheet A-2, Line 1b. 1.

2. Multiply Line 1 by **$338**. **Enter this amount on Schedule HSR, Part IV, Line 16.** 2. .00

INSTRUCTIONS FOR SCHEDULE HSR
DC HEALTH CARE SHARED RESPONSIBILITY PAYMENT
STOP: If you answered 'yes' to Part I, Line 1. DO NOT complete this schedule. Mark the oval on Line 3 of the D-40 and enter zero (0) on Line 25 of the D-40

DC law requires all residents to have health coverage, have an exemption, or pay a tax penalty on their D-40. DC enacted the law in response to the reduction of the federal individual responsibility payment and modeled it after the federal requirement. Beginning in 2020, all District residents must either:

(1) Have qualifying health care coverage (see definition below) for yourself, your spouse/registered domestic partner (if filing jointly or separately on the same return), and anyone you or your married/registered domestic partner claim (or can claim) as a dependent;

(2) Have a coverage exemption for yourself, your spouse/registered domestic partner (if filing jointly or separately on the same return), and anyone you or your married/registered domestic partner claim (or can claim) as a dependent; or

(3) Make a health care shared responsibility payment.

D-40

If you and, if applicable, all members of your shared responsibility family (see definition below) had qualifying health care coverage for every month in 2023, fill-in the oval on Page 1 of your D-40 and enter zero on Line 25 of your D-40. You do not need to complete Schedule HSR or make a shared responsibility payment. If you (and, if applicable, all members of your shared responsibility family) did not have qualifying health care coverage for every month in 2023, you must complete Schedule HSR to calculate your shared responsibility payment and/or to claim an exemption.

Schedule HSR

Part I - Complete Part I of the Schedule HSR. If you answer 'yes' to question 1, mark the oval on Line 3 of your D-40 and enter zero on Line 25. If you answer 'no' to question 1, you must complete Part II.

Part II - If you answer 'yes' to question 2, 3 or 4, skip Part III and continue to complete Part IV. Enter zero on Line 13-17 of Part IV and on Line 25 of the D-40. If you answer 'no' to questions 2-4, you must answer questions 5-6 and complete Part III.

Part III – Complete the name and taxpayer identification number (TIN) for each member of your shared responsibility family, the code for the exemption claimed and the number of exempt months claimed for each exemption type claimed. For a list of exemption codes, see the Exemption Chart.

- If you are claiming one exemption type for the entire year, enter the applicable exemption code and "12" for the number of exempt months claimed for that member.
- If you are claiming an exemption for less than 12 months, enter the applicable exemption code and the total number of months claimed for that exemption type for that member.
- If you are claiming multiple exemption types for one member, list that member more than once and enter exemption code and number of months claimed for each exemption type for that member.

Part IV – Complete Part IV of Schedule HSR to compute your shared responsibility payment. You must complete the worksheets to compute your shared responsibility payment. (If you claimed an exemption for all members of your shared responsibility family for every month of 2023, enter zero on Lines 13-17 of your Schedule HSR.) The worksheets contain the following:

A. **Flat Dollar Amount Calculation (Line 13)**
    1. Complete Worksheet A-1 if no exemptions are claimed by anyone in your shared responsibility family
    2. Complete Worksheet A-2 if exemptions are claimed for at least one month for at least one member of your shared responsibility family.
B. **Percentage Income Amount Calculation (Line 14)**
    1. Complete Worksheet B-1. (If you completed Worksheet A-2, you must also Complete Worksheet B-2.)
    2. Complete Worksheet B-2 if you claimed exemptions for at least one month for at least one member of your shared responsibility family.
C. **District Average Bronze Plan Premium Calculation (Line 16)**
    1. Complete Worksheet C-1 if no exemptions were claimed.
    2. Complete Worksheet C-2 if you claimed exemptions for at least one month for at least one member in your shared responsibility family.

A. Flat Dollar Amount Calculation Worksheets

- Worksheet A-1

Complete this worksheet if you are not claiming any exemptions for any month for any member of your shared responsibility family.

Follow the line by line directions provided on the form. Enter the amount from Line 5 on Schedule HSR, Part IV, Line 13. Proceed to Worksheet B-1.

- Worksheet A-2

Complete this worksheet only if you are claiming an exemption, including maintaining partial-year minimum essential coverage, for any month for any member of your shared responsibility family.

List the name of each member of your shared responsibility family in the provided row. Then, for each month, mark an X in the appropriate column listed for the member(s) of your shared responsibility family who did not have minimum essential coverage or a coverage exemption. For example, if your dependent “John” had a health care coverage only for the month of January and had no coverage exemptions for the remainder of the year, mark an “X” in each of the month columns February through December on the row associated with John’s name.

Line 1a: For each month, add the total number of “X’s” in the column. The maximum number entered in any month’s column is 5, even if that column includes more than 5 “X’s”. For example, if each of the 6 members of your shared responsibility family did not have health care coverage or a coverage exemption for January, you should enter “5” on Line 1 in the January column.

Line 1b: After you have completed the step above for each month, add the total calculated for each month together. Enter this sum on the provided space in the "Line 1b" box. For example, if you entered "5" in the January column for Line 1a, "4" in the April column, and "0" in all other columns, enter "9" in the space provided in the "Line 1b" box.

Line 2: Enter the total number of "X's" in each month that correspond to members age 18 or older as of December 31, 2023.

Line 3: Enter one-half the total number of "X's" in each month that correspond to members under the age of 18 as of December 31, 2023.

Line 4: Add Lines 2 and 3 for each month.

Line 5: Multiply Line 4 by $745 for each month. If $2,235 or more, enter $2,235.

Line 6: Total the amounts reported in each month's column on Line 5.

Line 7: Divide the amount reported on Line 6 by 12.0. This is your flat dollar amount. Enter this amount on Schedule HSR, Part IV, Line 13 and proceed to Worksheet B-1.

B. Percentage Interest Calculation Worksheets

Worksheet B-1

Complete this worksheet if you completed either Worksheet A-1 or Worksheet A-2. If you completed Worksheet A-2, you must also complete Worksheet B-2.

Follow the line by line directions provided on the form. The applicable D-40 filing threshold amounts for 2023 are:

- Single (under 65) – $13,850
- Single (65 or older) – $15,700
- Married/Registered domestic partner filing jointly or separately on the same return (both spouses under 65) – $27,700
- Married/Registered domestic partner filing jointly or separately on the same return (one spouse 65 or older) – $29,200
- Married/Registered domestic partner filing jointly or separately on the same return (both spouses 65 or older) – $30,700
- Married filing separately (under 65) – $13,850
- Married filing separately (65 or older) - $15,350
- Head of household (under 65) – $20,800
- Head of household (65 or older) – $22,650
- Qualifying Widow(er) (under 65) – $27,700
- Qualifying Widow(er) (65 or older) – $29,200

NOTE: The IRS does not consider 'blind' as an additional standard deduction.

If you completed Worksheet A-1, enter the amount from Line 4 on Schedule HSR, Part IV, Line 14 and proceed to Worksheet C-1. If you completed Worksheet A-2, proceed to Worksheet B-2 to calculate your percentage of income amount.

Worksheet B-2

Complete this worksheet only if you completed Worksheet A-2 (if you claimed exemptions for at least one month for at least one member of your shared responsibility family).

Line 1-12: For each month enter the amount from Worksheet A-2, Line 5 in column (a) and the amount from Worksheet B-1, Line 4 in column (b). In column (c), enter the larger of column (a) or column (b).

Line 13: Add the amounts reported in column (c) for Lines 1-12.

Line 14: Divide the total on Line 13 by 12. Enter this amount on Schedule HSR, Part IV, Line 14. Proceed to Worksheet C-2.

C. District Average Bronze Plan Premium Calculation Worksheets

Worksheet C-1

Complete this worksheet if you completed Worksheet A-1. Do not complete this worksheet if you completed Worksheet A-2 (if you claimed no exemptions for any member of your shared responsibility family).

Follow the line by line directions provided on the form. Enter the amount from Line 2 on Schedule HSR, Part IV, Line 16.

Worksheet C-2

Complete this worksheet if you completed Worksheet A-2. Do not complete this worksheet if you completed Worksheet A-1 (if you claimed exemptions for at least one month for at least one member of your shared responsibility family).

Follow the line by line directions provided on the form. Enter the amount from Line 2 on Schedule HSR, Part IV, Line 16.

Definitions

- **DC resident.** For purposes of Schedule HSR, DC resident has the same meaning as "resident" defined in D.C. Official Code § 47-1801.04(42). (Part-year residents should claim an exemption as a nonresident of the District for the month(s) during the tax year that he or she was not a DC resident.)

For additional information regarding qualifying coverage, contact DC Health Link at www.dchealthlink.com or (855) 532-5465.

- **Shared responsibility family**. For purposes of Schedule HSR, shared responsibility family includes the following individuals:
  - The taxpayer;
  - The taxpayer's spouse or registered domestic partner if they file D-40 jointly or separately on the same return; and
  - Any dependents that that the taxpayer (or the taxpayer's spouse registered domestic partner) claimed or could have claimed on their D-40.

- **Qualifying health coverage.** For purposes of Schedule HSR, qualifying health coverage means:

  - Minimum essential coverage as defined by section 5000A of the Internal Revenue Code of 1986 (26 U.S.C. § 5000A) and its implementing regulations, as that section and its implementing regulations were in effect on December 15, 2017;
  - The Immigrant Children's Program; and
  - Health coverage provided under a multiple employer welfare arrangement; provided, that the multiple employer welfare arrangement provided coverage in the District on December 15, 2017, or complies with federal law and regulations applicable to multiple employer welfare arrangements that were in place as of December 15, 2017.

Adjusted Gross Income ("AGI"). For purposes of Schedule HSR AGI is the federal AGI reported on Line 4 of your D-40 return. If you are filing a joint return or filing separately on the same return with your spouse or registered domestic partner, use the combined federal AGI reported on Line 4 of your D-40 return. If a member of your Shared Responsibility Family (spouse or dependent) filed a separate return, the federal AGI reported by that member on his or her separate return does not need to be added to the federal AGI reported on your D-40 for the purposes of calculating the shared responsibility payment on your return.

Exemptions Chart

Exemption Type	Exemption Code
Affordability—You received an affordability exemption certificate from the Health Benefits Exchange Authority. For information regarding the affordability exemption contact DC Health Link at www.dchealthlink.com or (855) 532-5465.	A
Short coverage gap—You went without coverage for less than 3 consecutive months during the year.	B
Citizens living abroad and certain noncitizens—You were: • A U.S. citizen or a resident alien who was physically present in a foreign country or countries for at least 330 full days during any period of 12 consecutive months; • A U.S. citizen who was a bona fide resident of a foreign country or countries for an uninterrupted period that includes the entire tax year; • A bona fide resident of a U.S. territory; • A resident alien who was a citizen or national of a foreign country with which the U.S. has an income tax treaty with a nondiscrimination clause, and you were a bona fide resident of a foreign country for an uninterrupted period that includes the entire tax year; • Not lawfully present in the U.S. and not a U.S. citizen or U.S. national. For more information about who is treated as lawfully present in the U.S. for purposes of this coverage exemption, visit www.HealthCare.gov; or • A nonresident alien, including (1) a dual-status alien in the first year of U.S. residency and (2) a nonresident alien or dual-status alien who elects to file a joint return with a U.S. spouse. This exemption doesn't apply if you are a nonresident alien for 2018, but met certain presence requirements and elected to be treated as a resident alien. For more information, see IRS Pub. 519.	C
Members of a health care sharing ministry—You were a member of a health care sharing ministry.	D
Members of Indian tribes—You were either a member of a federally recognized Indian tribe including an Alaska Native Claims Settlement Act (ANCSA) Corporation Shareholder (regional or village), or you were otherwise eligible for services through an Indian health care provider or the Indian Health Service.	E
Incarceration—You were in a jail, prison, or similar penal institution or correctional facility after the disposition of charges.	F
General hardship— You received a hardship exemption certificate from the Health Benefits Exchange Authority. For information regarding the hardship exemption contact DC Health Link at www.dchealthlink.com or (855) 532-5465.	G
Member of shared responsibility family born or adopted during the year—The months before and including the month that an individual was added to your shared responsibility family by birth or adoption. *You should claim this exemption only if you also are claiming another exemption in Part III.*	H
Member of shared responsibility family died during the year—The months after the month that a member of your shared responsibility family died during the year. *You should claim this exemption only if you also are claiming another exemption in Part III.*	H
Nonresident of the District – You were not a resident of the District of Columbia.	I
Sincerely Held Religious Belief —You lacked qualifying health coverage on the basis of a sincerely held religious belief during the entire taxable year.	J
DC Health Alliance – You were enrolled in the DC Health Alliance Program.	K

Low income– Your federal adjusted gross income reported on your D-40, Line 4 is equal to or below the amounts that correspond to the number of members in your shared responsibility family and the age of the individual for which the exemption is claimed. **(If you qualify for this exemption, you may be eligible for Medicaid. Contact DC Health Link at (855) 532-5465 or www.dchealthlink.com or the Department of Health Care Finance at (202) 727-5355 or https://dhcf.dc.gov/service/medicaid or for more information.)**	L

Number of Shared Responsibility Family Members:	If your AGI is equal to or below the following amounts, members age 21 or older as of 12/31/2023 are exempt:	If your AGI is equal to or below the following amounts, members under age 21 as of 12/31/2023 are exempt:
1	$32,367.60	$47,239.20
2	$43,778.40	$63,892.80
3	$55,189.20	$80,546.40
4	$66,600.00	$97,200.00
5	$78,010.80	$113,853.60
6	$89,421.60	$130,507.20
7	$100,832.40	$147,160.80
8	$112,243.20	$163,814.40
For Each Additional Member, add:	$11,410.80	$16,653.60

A Religious Sect that is Conscientiously Opposed - If you are a member of a religious sect that is conscientiously opposed to accepting health benefits, including Social Security and Medicare, and need to claim an exemption from the Shared Responsibility Payment.	M
Maintained Minimum Essential Coverage	Z