



Professional Income Tax Preparation

**JOEY'S INCOME TAX & ACCOUNTING SERVICES**

Get Your Taxes Done Now For the Maximum Refund!

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## INCOME TAX PREPARATION CHECKLIST

NAME: \_\_\_\_\_ CONTACT NO: \_\_\_\_\_

APPOINTMENT DATE: \_\_\_\_\_ TIME: \_\_\_\_\_

### THINGS TO BRING

<input type="checkbox"/> Social Security Cards(For New Clients)	<input type="checkbox"/> All Copies of W-2s and Any 1099 Statement
<input type="checkbox"/> Birthdates for each person on the Return	<input type="checkbox"/> W2G Gambling Winnings
<input type="checkbox"/> Last Year's Tax Return	<input type="checkbox"/> Student Loan Interest Statement
<input type="checkbox"/> 1099's Reporting Interest and Dividend Income	<input type="checkbox"/> Worksheet Summary of Business or Rental Income and Expenses
<input type="checkbox"/> All Forms reporting pension and Social Security Benefits	<input type="checkbox"/> 1099's Reporting Stock or Bond Sales-Purchase Date and Cost
<input type="checkbox"/> 1099's Reporting Unemployment Compensation and State	<input type="checkbox"/> Escrow Settlement Statement for any property bought or sold

### ITEMIZED DEDUCTION CHECKLIST

<u>MEDICAL &amp; DENTAL EXPENSES</u>		<u>TAXES</u>	<u>AMOUNT</u>	<u>MISCELLANEOUS</u>	<u>AMOUNT</u>		<u>AMOUNT</u>
Insurance Premiums		Payments to State		Union Dues		Car Registration	
Long Term Care Insurance		Real State		Tax Prep Fee		Mileage	
Dr. Visits/Co Pays		Supplemental R/E		Supplies/Tools		Health Insurance	
Prescriptions		Personal Property		Professional License			
Dental Expenses		Auto License		Business Travel			
Hospital Expenses							
Glasses/Contacts							
Hearing Aids							
Batteries							
Medical Miles							

  

<u>CONTRIBUTIONS</u>	<u>AMOUNT</u>	<u>EXPENSES</u>	<u>AMOUNT</u>	<u>EXPENSES</u>	<u>AMOUNT</u>
Church		Job Search		Work Shoes	
Goodwill		Phone Bills		Work Tools	
Salvations Army		Licensing		Business Phone	
Veterans/Volunteer		Work Uniforms		Business Meals	
United Way		Education		Business Mileage	

Waterside Center  
3200 Guasti Road, Suite 100 Ontario, CA 91761



**PERSONAL INFORMATION**

**PRIMARY TAXPAYER**

Name: \_\_\_\_\_

SSN#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

*Filing Status:*

- Single
- Married Filing Jointly
- Married Filing Separately
- Head of Household
- Qualifying Widow(er) with Dependent

Contact Info

Contact# : \_\_\_\_\_

Email: \_\_\_\_\_

Part/Full-Time Student?: \_\_\_ YES \_\_\_ NO

**SPOUSE**

Name: \_\_\_\_\_

SSN#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Zip: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

*Filing Status:*

- Single
- Married Filing Jointly
- Married Filing Separately
- Head of Household
- Qualifying Widow(er) with Dependent

Contact Info

Contact# : \_\_\_\_\_

Email: \_\_\_\_\_

Part/Full-Time Student?: \_\_\_ YES \_\_\_ NO

Months covered in Medical Insurance Last Year? \_\_\_\_

Claimed as a Dependent on someone else Return?

\_\_\_ YES \_\_\_ NO

Months covered in Medical Insurance Last Year? \_\_\_\_

Claimed as a Dependent on someone else Return?

\_\_\_ YES \_\_\_ NO

Refund will be deposited to an Account? YES \_\_\_ NO \_\_\_

If YES? ROUTING NO: \_\_\_\_\_

ACCOUNT NO: \_\_\_\_\_

Refund will be deposited to an Account? YES \_\_\_ NO \_\_\_

If YES? ROUTING NO: \_\_\_\_\_

ACCOUNT NO: \_\_\_\_\_





**DEPENDENTS**

1

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Relationship: \_\_\_\_\_

Dependent who lives with you? YES\_\_ NO\_\_

If YES? Months lived with you Last Year?: \_\_\_\_

Has a *Dependent Care Provider*? YES\_\_ NO\_\_

If YES? See last page

Part/Full-Time Student?: YES\_\_ NO\_\_

Months Covered in Medical Insurance Last Year?  
\_\_\_\_\_

2

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Relationship: \_\_\_\_\_

Dependent who lives with you? YES\_\_ NO\_\_

If YES? Months lived with you Last Year?: \_\_\_\_

Has a *Dependent Care Provider*? YES\_\_ NO\_\_

If YES? See last page

Part/Full-Time Student?: YES\_\_ NO\_\_

Months Covered in Medical Insurance Last Year?  
\_\_\_\_\_

3

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Relationship: \_\_\_\_\_

Dependent who lives with you? YES\_\_ NO\_\_

If YES? Months lived with you Last Year?: \_\_\_\_

Has a *Dependent Care Provider*? YES\_\_ NO\_\_

If YES? See last page

Part/Full-Time Student?: YES\_\_ NO\_\_

Months Covered in Medical Insurance Last Year?  
\_\_\_\_\_

4

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

Date of Birth (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_/

Relationship: \_\_\_\_\_

Dependent who lives with you? YES\_\_ NO\_\_

If YES? Months lived with you Last Year?: \_\_\_\_

Has a *Dependent Care Provider*? YES\_\_ NO\_\_

If YES? See last page

Part/Full-Time Student?: YES\_\_ NO\_\_

Months Covered in Medical Insurance Last Year?  
\_\_\_\_\_



**CHILD CARE PROVIDER**

**( for dependents )**

- Name: \_\_\_\_\_
- Address: \_\_\_\_\_ Zip: \_\_\_\_\_
- City: \_\_\_\_\_ State: \_\_\_\_\_

- SS# or EIN# for Child Care Provider:  
\_\_\_\_\_

- Child Names:
  - 1) \_\_\_\_\_
  - 2) \_\_\_\_\_
  - 3) \_\_\_\_\_
  - 4) \_\_\_\_\_
  - 5) \_\_\_\_\_

**EDUCATIONS**

- *Registration and Tuition Expenses for ANY ( Yourself, Your Spouse, and I or Dependent) College Education.*
- *College Education*
- *Copy of Form 1098-T from Institution*
- *Course Material such as Books, ETC.*

**RESIDENTIAL SOLAR ENERGY CREDIT**

***Bring purchase contract for the material and installation of your residential Solar Unit and Manufacturer's Certification.***

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