

# Salyers Financial Group LLC

Tax Prep Routing

## Personal Data

Name \_\_\_\_\_ SS# \_\_\_\_\_ Birthday \_\_\_\_\_  
Spouse \_\_\_\_\_ SS# \_\_\_\_\_ Birthday \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
County \_\_\_\_\_ School District \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Occupation \_\_\_\_\_ Spouse \_\_\_\_\_  
Email \_\_\_\_\_

**Did You Move?** Y / N

Previous Address \_\_\_\_\_

Date Moved \_\_\_\_\_

## Dependents

Name	Bday/Age	SS#	Relation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Filing Status:** 1. Single 2. Married Joint 3. Married Separate 4.HOH 5. Qual. Wid.

## Refund Choice

Direct Deposit / Check Mailed to Home

## Balance Due

Direct Debit / Pay Voucher

Date of direct debit \_\_\_\_\_

## Bank Information

Bank Name \_\_\_\_\_ Checking or Savings \_\_\_\_\_

Routing Number \_\_\_\_\_ Account Number \_\_\_\_\_

## Identification Verification:

Drivers License Number \_\_\_\_\_ Issue State \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

Drivers License Number \_\_\_\_\_ Issue State \_\_\_\_\_ Issue Date \_\_\_\_\_ Expiration Date \_\_\_\_\_

## ACA Compliance

Did you maintain minimum essential health coverage all year for you and/or your dependents? Y/N

Type: Marketplace Individual Plan Employer Plan Retiree Plan Medicare Medicaid

C.H.I.P TRICare Veterans Programs Peace Corp Plan Student Self-Funded

**Notes:**