Government of the
District of Columbia

2023 Schedule HSR SUB
DC Health Care
Shared Responsibility

Unless Instructed otherwise- if you fill
any part of this schedule, attach it to your D-40

SOFTWARE DEVELOPER USE ONLY VENDOR ID#

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.

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.
If amount is zero, leave line blank.

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