

**REQUIRED**

If your income on line 29 is above the filing threshold, you **must** submit this schedule with your return.

Name(s) as shown on Form NJ-1040	Social Security Number
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**Schedule NJ-HCC**

Health Care Coverage

**2020**

If your income on line 29 is at or below the filing threshold, do not complete this schedule.

**PART I**

Did you and, if applicable, all members of your tax household, have minimum essential health coverage for every month in 2020? (See instructions for line 53, NJ-1040.) Part-year residents include only months as a New Jersey resident.

- Yes. You do not owe a shared responsibility payment. Fill in the oval at line 53, NJ-1040, and enclose this schedule with your return.
- No. Continue to Part II.

**PART II**

Enter the name and Social Security number for each member of your tax household. Check the box for every month each person had minimum essential health coverage or qualified for an exemption (part-year residents include only months as a New Jersey resident). If an individual qualified for an exemption, enter the exemption number. (See instructions for line 53, NJ-1040.) If an individual has more than one exemption number, check the box. If you need more space, enclose a statement listing any additional individuals.

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Name	Social Security Number												
Exemption number:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
													Check box if this individual has more than one exemption number <input type="checkbox"/>

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Name	Social Security Number												
Exemption number:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
													Check box if this individual has more than one exemption number <input type="checkbox"/>

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Name	Social Security Number												
Exemption number:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
													Check box if this individual has more than one exemption number <input type="checkbox"/>

		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Name	Social Security Number												
Exemption number:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
													Check box if this individual has more than one exemption number <input type="checkbox"/>

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Name	Social Security Number												
Exemption number:		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
													Check box if this individual has more than one exemption number <input type="checkbox"/>

**Keep a copy of this schedule for your records**