Welcome to JPS Connection

Thank you for allowing JPS Health Network the opportunity to provide your medical care.

JPS Health Network connects you and your family to healthcare. JPS Connection provides affordable access to healthcare with inexpensive co-pays for doctor appointments, specialized care, and prescriptions.

JPS offers Financial Assistance to eligible individuals. We serve the healthcare needs of all patients, regardless of ability to pay. Connection members have the benefit of a medical home – meaning you have a physician or nurse practitioner assigned to you and your family. You get access to preventative care such as physicals and screenings that will help keep you healthy and out of the emergency room.

Eligibility for JPS Connection is determined based on a review of a completed application and supporting documents. The minimum requirements for assistance are:

1. **Residence:** The applicant must live in Tarrant County.
2. **Citizenship:** The applicant must be a U.S. Citizen or a Legal Permanent Resident.
3. **Income:** The household's monthly gross income must not exceed 250% of the Federal Poverty Income Limit (FPIL).
4. **Healthcare Coverage:** The applicant must pursue and accept all available health insurance assistance prior to receiving any assistance from JPS Connection.

The JPS Connection program offers assistance for services provided by JPS Health Network. Assistance may also be available for prior visits if you qualify. Patients and families will not be charged more for emergency or other medically necessary care than amounts generally billed to those patients who have insurance.

Applications are available at the Eligibility Centers, in all registration areas, and in the Emergency room. Applications can also be downloaded at ***JPSConnection.org***. Translation services and arrangements are available upon request.

How to Apply for a Membership

1. Fill out the application and gather your required documents.
2. Submit application and documents to a JPS Eligibility Center
   - In person at any JPS Eligibility Center
   - By fax: **817-702-3834**
   - By email: **enroll@jpshealth.org**
   - By mail: JPS Eligibility Center
     101 W. Allen Avenue
     Fort Worth, TX 76110

How to Renew Your Membership

1. Begin the renewal process at ***ola.veritysource.com/jps***.
2. You will need your medical record number to complete your online renewal. If you do not know your medical record number, please contact us at **817-702-1001**. If you receive an error message after submitting your online renewal, this unfortunately means that you are not eligible to renew online at this time and must reapply for membership.

Eligibility & Enrollment Locations

John Peter Smith Hospital - Admissions 1500 S. Main Street, Fort Worth, TX 76104	**Monday - Friday** 8 a.m. - 4:30 p.m.
Eligibility & Enrollment Center - Main Campus 101 W. Allen Avenue, Fort Worth, TX 76110	**Monday - Friday** 8 a.m. - 6 p.m.
Stop Six-Walter B. Barbour Health Center 3301 Stalcup Road, Fort Worth, TX 76119	**Monday - Friday** 8 a.m. - 4:30 p.m.
Diamond Hill Health Center 3308 Deen Road, Fort Worth, TX 76106	**Monday - Friday** 8 a.m. - 6 p.m. **Third Saturday of the month** 8 a.m. - Noon
Medical Home Southeast Tarrant 1050 W. Arkansas Lane, Arlington, TX 76013	**Monday - Friday** 8 a.m. - 4:30p.m. **Fourth Saturday of the month** 8 a.m. - Noon
Oncology & Infusion Center 1450 8th Avenue, Fort Worth, TX 76104	**Monday - Friday** 8 a.m. - 4:30 p.m.
Family Health Center 1500 S. Main Street, 4th Floor, Fort Worth, TX 76104	**Monday - Friday** 8 a.m. - 4:30 p.m.
South Campus Health Center 2500 Circle Drive, Fort Worth, TX 76119	**Monday - Friday** 8 a.m. - 6 p.m. **Fourth Saturday of the month** 8 a.m. - Noon
Viola Pitts-Como Health Center 4701 Bryant Irvin Road North, Fort Worth, TX 76107	**Monday - Friday** 8 a.m. - 6 p.m. **Second Saturday of the month** 8 a.m. - Noon
Gertrude Tarpley-Watauga Health Center 6601 Watauga Road, Suite 124, Watauga, TX 76148	**Monday - Friday** 8 a.m. - 4:30 p.m.
Medical Home Northeast Tarrant 3200 W. Euless Boulevard, Euless, TX 76040	**Monday - Friday** 8 a.m. - 6 p.m. **First Saturday of the month** 8 a.m. - Noon
JPS Center for Behavioral Health Recovery 601 W. Terrell Avenue, Fort Worth, TX 76104	**Monday** 8 a.m. - noon
Medical Home True Worth 1501 E. Presidio Street, Fort Worth, TX 76102	**Monday - Friday** 8 a.m. - 4:30 p.m.

Documentation Requirements

Please provide all applicable items from following categories: *Please note that upon receipt of documentation, additional information may be requested.*

1. **Proof of Patient Identification** - Must provide one of the following or contact office for other options.
   - Driver's License or State ID Card
   - Government-Issued ID
   - Birth Certificate (Children Under 19)
   - Homeless Scan Card
   - Current Work Identification Card (With Picture)
   - Current School Identification Card (With Picture)
   - Passport

2. **Immigration Documentation** - For all application household members.
   - Resident alien cards, Certificate of Naturalization, Birth Certificates, I-94 card, Immigrant Visas with I-551 Endorsement, or Passports
   - Alien Number for Verification

3. **Bank Statements, Investments, and Tax Returns** - All pages are required.
   - Most Recent Checking and Savings Account Statements (All pages are required)
   - IRS Form 4506T for Personal and Business, If Self-Employed
   - Most Recent Statement of CDs, IRAs, and Other Investments

4. **Proof of Employment and Income** - Must provide one month proof of income.
   - Payroll Check Stubs
   - Employment Verification Form
   - Current Award Letter for SSI, RSDI, VA, Social Security, TANF
   - Workman's Compensation
   - Employer Statement of Earnings on Letterhead
   - Court Orders/Check or Debit Card Statement for Child Support/Alimony
   - Unemployment Award Letter

5. **Verification Sources of Assistance** - Provide All Applicable.
   - Food Stamp, TANF, or Housing Assistance Award Letters
   - Statement from Homeless Shelter Where Patient Resides and Verifying Unemployment
   - Verification of Assistance Form Completed by the Person Providing Assistance

6. **Social Security Number** - Provide for all applicable household members.

7. **Proof of Patient Residency** - Must provide a minimum of two.
   - Utility, Telephone, and Cable Bills
   - Lease Agreement/Mortgage Statement
   - Auto, Life, Homeowner's/Renter's Insurance Documents
   - City, County, State/Federal Agencies Correspondence
   - Texas Department of Motor Vehicles Records
   - Statement from Homeless Shelter

8. **Proof of Healthcare Coverage/Insurance** - Provide for all household members.
   - Front and Back of Medical/Dental Insurance Cards
   - Call the Office for Assistance with Marketplace Enrollment or Exemption (817-702-1001)

9. **Proof of Self-Employment** - No taxes withheld from income.
   - Three (3) Self-Employment Forms
   - Form 4506-T

10. **Acceptable Sources to Verify Self-Employment Deductions** - If desiring to claim expenses from self-employment.
    - Receipts

11. **Acceptable Sources to Verify Deductions** - If desiring to claim deductions for alimony or child support paid out.
    - Court Order
    - Statement from Attorney General's Office
    - Deductions Listed on Most Recent Check Stubs.

Please note: Anyone who knowingly likes or misrepresents the truth or arranges for someone to knowingly lie or misrepresents the truth in the completion of the application process is committing a crime, which can be punished under Federal law, State law, or both. *If at any time false information is discovered, penalties will include, but are not limited to, loss of my membership benefits and the inability to reapply for the JPS Connection Indigent Healthcare Program for no less than a period of ninety (90) days.*

Application for JPS Connection Financial Assistance

JPS Connection is not an insurance plan. JPS Connection does not provide health insurance coverage under the Federal Health Insurance Marketplace Exchange.

Name: _____ **Maiden Name**: _____
(Last) (First) (MI)

Address: _____ **Phone #:** _____
(Street) (Apt. #) (City) (State) (Zip) (County)

Living Arrangements: ❑ Own ❑ Rent ❑ Living with Someone ❑ Shelter/Homeless

Email Address: _____ **Country of Birth :** _____

Marital Status: ❑ Single ❑ Separated ❑ Divorced ❑ Widowed ❑ Married ❑ Common Law/Domestic Partner

Ethnicity: ❑Caucasian ❑African-American ❑Hispanic ❑ Asian ❑ Native American ❑ Other _____

Primary Language: ❑ English ❑ Spanish ❑Vietnamese ❑ Other _____ **Is anyone pregnant?** ❑ Yes ❑ No

Does anyone in the household receive government assistance? (Food stamps, Housing, TANF, etc.) ❑ Yes ❑ No

List the names of each person living in household (attach additional sheets as necessary)

Name (Last, First, Middle Initial)	Relationship	Sex (Male or Female)	Date of Birth	Social Security #	Employed	US Citizen or Legal Permanent Resident	Is Person Applying?
1)	SELF				Y / N	Y / N	Y / N
2)	SPOUSE				Y / N	Y / N	Y / N
3)					Y / N	Y / N	Y / N
4)					Y / N	Y / N	Y / N

Household Information – Required for each adult member of household

	1) SELF	2) SPOUSE	3) CHILD	4) CHILD
Monthly Income				
Employer Name				
Employment Income – Gross monthly amount:	$	$	$	$
Self-Employment Business Name				
Self-Employment Monthly Income after expenses	$	$	$	$
Last **Year** Income Tax was Filed				
Unemployment	$	$	$	$
Worker's Compensation	$	$	$	$
Pensions / Retirement	$	$	$	$
Social Security RSDI	$	$	$	$
Disability Income or SSI Income	$	$	$	$
VA Benefits	$	$	$	$
Other / Money Received from Family and Friends	$	$	$	$
Expenses - Monthly				
Court Ordered Child Support/Alimony	$	$	$	$
Assets				
Bank Name(s)				
Bank Account Balances	$	$	$	$
IRA/Other Investments	$	$	$	$
Other Medical Coverage				
Does this person have any medical coverage? (Medicare, Medicaid/CHIP, VA, Tricare, Marketplace, Employer, Private, or Other)	Name of Coverage: _____	Name of Coverage: _____	Name of Coverage: _____	Name of Coverage: _____

"I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under federal law and/or state law. Everything on this application is the truth as best I know it." I authorize JPS Health Network to obtain electronic records for the purpose of making a determination of whether I meet the eligibility requirements for the JPS Connection Program. I also understand that any approval will be conditional based on the information reviewed in my records.

Your Signature _____ Date: _____

Signature of Spouse or Common Law Spouse/Partner _____ Date: _____

Signature of your dependent child 19-26, whose lives in the home _____ Date: _____

Signature of Applicant's Representative _____ Date: _____

Name of person who helped you complete this form _____ Phone # _____

JPS Health Network
Membership Responsibilities for
JPS Connection Indigent Healthcare Program

- JPS Connection is a tax-supported medical program offered to eligible Tarrant County residents. JPS Connection offers low cost medical care available only through JPS Health Network facilities. **I understand that JPS Connection is not an insurance company or an insurance plan.**

- I understand that the JPS Connection does not cover all of the services provided at JPS Health Network including, but not limited to dental, cosmetic procedures, maternity services, assisted reproductive technology, and transplants. Motor vehicle accidents are not covered by JPS Connection when there is the presence of other insurance. JPS Connection remains the payor of last resort for all services.

- I understand that if I am deemed eligible for state or federal assistance, pharmaceutical assistance programs, or insurance, I must comply with seeking that assistance before receiving any assistance from the JPS Connection Program. This includes any third party commercial insurance, Medicaid, VA benefits and/or parts AB&D of Medicare. Failure to do so will make me ineligible for JPS Connection. Documentation provided to JPS Health Network will be used to apply for any coverage for which I may be potentially eligible.

- I authorize the Tarrant County Hospital District of Fort Worth to release any demographic and financial information requested by representatives, agents or intermediaries of local, state, or federal agencies; insurance companies; pharmaceutical assistance programs; or other organizations or entities as may be required by said representative for payment of claims arising from services provided under the JPS Connection Program.

- As a JPS Connection member, I understand I am responsible for the co-payments for services rendered. I have been provided a copy of the JPS Connection Co-pay Schedule.

- I am aware that when JPS Connection is used supplemental to another payor, I am responsible for all physician/professional fees, co-payments and any deductibles related to professional services rendered. This includes, but not limited to, Acclaim, UNT, Sheridan, RadCare, IES or any other professional group you may receive bills from.

- As a JPS Connection member, I understand that I have an obligation to notify the Financial Screening department of JPS Health Network of any changes. I agree to inform the Financial Screening department of the JPS Health Network immediately of any changes in my Tarrant County residence, household income, family size and insurance coverage. Failure to do so, may result in loss of membership benefits.

- I understand that the JPS Connection membership privileges are on a limited time basis. In order to continue receiving a discount on medical services, through the JPS Connection program, it will be necessary to complete another financial screening at the end of my enrollment period. I understand I will be expected to pay all charges incurred after eligibility has expired.

- I acknowledge that should the JPS Health Network receive returned mail, from the mailing address I provided, that my JPS Connection membership privileges will be suspended pending further review.

- I understand that I am responsible for providing true and accurate documentation. If at any time false information is discovered penalties may include, but not limited to, loss of my membership benefits and the inability to reapply for the JPS Connection Indigent Healthcare Program for no less than a period of ninety (90) days.

"I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I know it."

Signature of Applicant: _____ Date: _____

Signature of Co-Applicant: _____ Date: _____

JPS Health Network

Verification of Assistance and Residency for JPS Connection Program

This form only needs to be completed if the applicant is being assisted by another individual.

I, _____ verify that_____
Name of person providing assistance — Applicant(s) full name

Patient's MR# _____ and/or Social Security # _____ lives at

_____
Applicant(s) Address — City/Zip Code

Financial Assistance: I provide financial assistance to the applicant. Yes No

This individual is claimed as a dependent on my most recent filed income tax return. Yes No

Does the applicant have a job? _____ If yes, provide employer name_____

Does the applicant have another income source? _____ If yes, how much _____

I provide applicant with the following: ❑ Food ❑ Personal items ❑ Transportation

❑ **Cash/Check $ _____** per Week or Month ❑ Other _____

Do you pay rent or other bills for this applicant? _____ If yes, how much and how often? _____

Residency Assistance (check all that apply):

- ❑ The applicant(s) resides at my Tarrant County residence.
- ❑ The applicant(s) does not pay rent to me.
- ❑ The applicant(s) pays _____ to help toward the rent and utilities.

How long has the applicant(s) resided at your address? _____

Does the applicant(s) have another residence? _____ If yes, where _____

Relationship of Person Providing the Assistance to the Applicant(s): _____

I certify that the above information is true and correct. "I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under federal law and/or state law. Everything on this application is the truth as best I know it."

Signature of the Person Providing the Assistance: _____

Address, City, State, Zip: _____

Phone Number: _____

Date signed: _____

JPS Health Network

Statement of Self-Employment for
JPS Connection Indigent Healthcare Program

List your business income and expenses for each month employed up to 3 months (one form per month)

***Important: Receipts or other proof required to deduct expenses.**

Name of Person Having Self-Employment Income:

Describe what you did to earn this money:

How long have you been Self Employed?

Business Expenses

Write in the dates you paid the expenses and the amount of each expense. Expenses are your costs of doing business. Ex: supplies, repairs, rent, utilities, seed, feed, business insurance, licenses, fees, your social security contribution for people who worked for you, and labor (not salaries you pay yourself).

Date	Type of Expense	Amount
Total Self-Employment Expenses		**$**

Business Income

List dates income was received and the amount for each date. Income includes money from sales, commissions, leases, tips, or whatever you do or sell for money.

Ex: babysitting, contract/sub-contract work, landscaping, day labor, panhandling, hairdressers and manicurist

Date	Type of Income	Amount
Total Self Employment Income		**$**
Enter Expenses & Subtract Here		**- $**
Net Self-Employment Income		**=$**

"I understand that anyone who knowingly lies or misrepresents the truth or arranges for someone to knowingly lie or misrepresent the truth in the completion of this application is committing a crime which can be punished under Federal law, State law, or both. Everything on this application is the truth as best I know it." If at any time false information is discovered penalties will include, but are not limited to, loss of my membership benefits and the inability to reapply for the JPS Connection Indigent Healthcare Program for no less than a period of ninety (90) days.

Signature of Applicant: Date:

Form **4506-C** (October 2022)

Department of the Treasury - Internal Revenue Service

IVES Request for Transcript of Tax Return

OMB Number 1545-1872

Do not sign this form unless all applicable lines have been completed.

Request may be rejected if the form is incomplete or illegible.

For more information about Form 4506-C, visit *www.irs.gov* and search IVES.

1a. Current name			**2a**. Spouse's current name *(if joint return and transcripts are requested for both taxpayers)*		
i. First name	**ii**. Middle initial	**iii**. Last name/BMF company name	**i**. Spouse's first name	**ii**. Middle initial	**iii**. Spouse's last name

1b. First taxpayer identification number *(see instructions)*	**2b.** Spouse's taxpayer identification number *(if joint return and transcripts are requested for both taxpayers)*

1c. Previous name shown on the last return filed if different from line 1a			**2c**. Spouse's previous name shown on the last return filed if different from line 2a		
i. First name	**ii**. Middle initial	**iii**. Last name	**i**. First name	**ii**. Middle initial	**iii**. Last name

3. Current address *(including apt., room, or suite no.)*, city, state, and ZIP code *(see instructions)*			
a. Street address *(including apt., room, or suite no.)*	**b**. City	**c**. State	**d**. ZIP code

4. Previous address shown on the last return filed if different from line 3 *(see instructions)*			
a. Street address *(including apt., room, or suite no.)*	**b**. City	**c**. State	**d**. ZIP code

5a. IVES participant name, ID number, SOR mailbox ID, and address			
i. IVES participant name NCS TRV PROCESSING	**ii**. IVES participant ID number	**iii**. SOR mailbox ID	
iv. Street address *(including apt., room, or suite no.)* P.O. BOX 1089	**v**. City HAMMONTON	**vi**. State NJ	**vii**. ZIP code 08037
5b. Customer file number *(if applicable)* *(see instructions)*	**5c**. Unique identifier *(if applicable)* *(see instructions)*		

5d. Client name, telephone number, and address *(this field cannot be blank or not applicable (NA))*			
i. Client name TARRANT COUNTY HOSPITAL DISTRICT			**ii**. Telephone number 817-702-1001
iii. Street address *(including apt., room, or suite no.)* 1500 S MAIN STREET	**iv**. City FORT WORTH	**v**. State TX	**vi**. ZIP code 76104

Caution: This tax transcript is being sent to the third party entered on Line 5a and/or 5d. Ensure that lines 5 through 8 are completed before signing. *(see instructions)*

6. **Transcript requested**. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request for line 6 transcripts

a. Return Transcript ☐ **b.** Account Transcript ☐ **c.** Record of Account ☐

7. Wage and Income transcript *(W-2, 1098-E, 1099-G, etc.)* ☐

a. Enter a max of three form numbers here; if no entry is made, all forms will be sent.

b. Mark the checkbox for taxpayer(s) requesting the wage and income transcripts. If no box is checked, transcripts will be provided for all listed taxpayers

Line 1a ☐ Line 2a ☐

8. Year or period requested. Enter the ending date of the tax year or period using the mm dd yyyy format *(see instructions)*

/ / / / / / / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or, if applicable, line 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign; however, if both spouses' names and TINs are listed in lines 1a-1b and 2a-2b, both spouses must sign the request. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-C on behalf of the taxpayer. **Note**: This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the above attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-C. See instructions.**

Sign Here

Signature for Line 1a *(see instructions)*	Date	Phone number of taxpayer on line 1a or 2a
☐ Form 4506-C was signed by an Authorized Representative	☐ Signatory confirms document was electronically signed	
Print/Type name		
Title *(if line 1a above is a corporation, partnership, estate, or trust)*		
Spouse's signature *(required if listed on Line 2a)*		Date
☐ Form 4506-C was signed by an Authorized Representative	☐ Signatory confirms document was electronically signed	
Print/Type name		

Instructions for Form 4506-C, IVES Request for Transcript of Tax Return

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-C and its instructions, go to *www.irs.gov* and search IVES. Information about any recent developments affecting Form 4506-C (such as legislation enacted after we released it) will be posted on that page.

What's New. Form 4506-C includes the Client company requesting transcripts and increased the number of Wage and Income transcripts requests.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Designated Recipient Notification. Section 6103(c) limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Section 6103(c) limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506-C to request tax return information through an authorized IVES participant. You will designate an IVES participant to receive the information on line 5a.

Note: If you are unsure of which type of transcript you need, check with the party requesting your tax information.

Where to file. The IVES participant will fax Form 4506-C with the approved IVES cover sheet to their assigned Service Center.

Chart for ordering transcripts

If your assigned Service Center is:	Fax the requests with the approved coversheet to:
Austin Submission Processing Center	Austin IVES Team 844-249-6238
Kansas City Submission Processing Center	Kansas City IVES Team 844-249-8128
Ogden Submission Processing Center	Ogden IVES Team 844-249-8129

Specific Instructions

Line 1a/2a *(if spouse is also requested)*. For IMF Requests: Enter the First, Middle Intial, and Last Name in the indicated fields. If all characters will not fit, please enter up to 12 for First name and 22 for Last name. For BMF Requests: Enter the company name in the Last Name field. If all characters will not fit, please enter up to 22.

Line 1b/2b *(if spouse is also requested)*. Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a including the dashes in the correct format, or enter the employer identification number (EIN) for the business listed on line 1a including the dashes in the correct format.

Line 1c/2c *(if spouse is also requested)*. Enter your previous name as shown on your last filed tax return if different than line 1a.

Line 3. Enter your current address in the indicated fields. If you use a P.O. Box, include it and the number in the Current Address field.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B, Change of Address or Responsible Party — Business, with Form 4506-C.

Line 5b. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number cannot contain an SSN, ITIN or EIN. Completion of this line is not required.

Line 5c. Enter up to 10 alpha-numeric characters to create a unique identifier that will show in the mailbox file information. The unique identifier cannot contain an SSN, ITIN or EIN. Completion of this line is not required.

Note. If you use an SSN, we will not input the information and the customer file number or unique identifier will reflect a generic entry of "9999999999".

Line 5d. Enter the Client company name, address, and phone number in the indicated fields. A Client company receives the requested tax transcripts from the IVES participant. If the IVES participant is also the Client company, the IVES participant information should be entered on Line 5a and 5d. These fields cannot be blank or Not Applicable (NA).

Line 6. Enter only one tax form number (1040, 1065, 1120, etc.) per request for all line 6 transcripts request types.

Line 6a. Return Transcript includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-H, Form 1120-L, and Form 1120-S. Return transcripts are available for the current year and returns processed during the prior 3 processing years.

Line 6b. Account Transcript contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns.

Line 6c. Record of Account provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years.

Line 7. The IRS can provide a transcript that includes data from these information returns: Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. Enter up to three information return types. If no specific type is requested, all forms will be provided. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, Form W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need Form W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213.

Line 8. Enter the end date of the tax year or period requested in mm dd yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12 31 2018 for a calendar year 2018 Form 1040 transcript.

You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed if unchecked.

Signature and date. Form 4506-C must be signed and dated by the taxpayer listed on line 1a and, if listed, 2a. The IRS must receive Form 4506-C within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, including lines 5a through 8, are completed before signing.

Authorized Representative: A representative can sign Form 4506-C for a taxpayer if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5a, and Form 2848 is attached to the Form 4506-C request. If you are Heir at Law, Next of Kin, or Beneficiary, you must be able to establish a material interest in the estate or trust. If Form 4506-C is signed by a representative, the Authorized Representative check box must be marked.

Electronic Signature: Only IVES participants that opt in to the Electronic Signature usage can accept electronic signatures. Contact the IVES participant for approval and guidance for electronic signatures. If the Form 4506-C is signed electronically, the Electronic Signature check box must be marked.

Individuals. Transcripts listed on line 6 may be furnished to either spouse if jointly filed. Signatures are required for all taxpayers listed on Line 1a and 2a.

Corporations. Generally, Form 4506-C can be signed by:

(1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-C but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-C can be signed by any person who was a member of the partnership during any part of the tax period requested on line 8.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-C will vary depending on individual circumstances. The estimated average time is:

Learning about the law or the form . . . . . 10 min.
Preparing the form . . . . . 12 min.
Copying, assembling, and sending the form to the IRS . . . . . 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-C simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see Where to file on this page.