



225020050

\$

OR FISCAL YEAR BEGINNING _____ 2022, ENDING _____

Your Social Security Number _____ Spouse's Social Security Number _____

Your First Name _____ MI _____

Your Last Name _____

Does your name match the name on your social security card? If not, to ensure you get credit for your personal exemptions, contact SSA at 1-800-772-1213 or visit **www.ssa.gov**.

Spouse's First Name _____ MI _____

Spouse's Last Name _____

Current Mailing Address Line 1 (Street No. and Street Name or PO Box) _____

Current Mailing Address Line 2 (Apt No., Suite No., Floor No.) _____ City or Town _____ State _____ ZIP Code + 4 _____

Foreign Country Name _____ Foreign Province/State/County _____

Foreign Postal Code _____

REQUIRED: Maryland Physical address of taxing area as of December 31, 2022 or last day of the taxable year for fiscal year taxpayers. **See Instruction 6. Part-year residents see Instruction 26.**

4 Digit Political Subdivision Code (See Instruction 6) _____ Maryland Political Subdivision (See Instruction 6) _____

Maryland Physical Address Line 1 (Street No. and Street Name) (No PO Box) _____

Maryland Physical Address Line 2 (Apt No., Suite No., Floor No.) (No PO Box) _____

City _____ MD State _____ ZIP Code + 4 _____ Maryland County _____

FILING STATUS

CHECK ONE BOX ▶

See Instruction 1 if you are required to file.

- 1. Single (If you can be claimed on another person's tax return, use Filing Status 6.)
- 2. Married filing joint return or spouse had no income
- 3. Married filing separately, Spouse SSN ▶ _____
- 4. Head of household
- 5. Qualifying widow(er) with dependent child
- 6. Dependent taxpayer (Enter 0 in Exemption Box (A) - See Instruction 7.)

PART-YEAR RESIDENT

See Instruction 26.

Dates of Maryland Residence (MM DD YYYY) FROM _____ TO _____

Other state of residence: _____

If you began or ended legal residence in Maryland in 2022 place a **P** in the box. ▶

MILITARY: If you or your spouse has **non-Maryland** military income, place an **M** in the box. ▶

Enter **Military Income** amount here: _____



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NAME _____ SSN _____

EXEMPTIONS

See Instruction 10. Check appropriate box(es). NOTE: If you are claiming dependents, you must attach the Dependents' Information Form 502B to this form to receive the applicable exemption amount.

A. Yourself Spouse Enter number checked See Instruction 10 A. \$ _____
B. 65 or over 65 or over
Blind Blind Enter number checked X \$1,000 B. \$ _____
C. Enter number from line 3 of Dependent Form 502B See Instruction 10 C. \$ _____
D. Enter Total Exemptions (Add A, B and C.) Total Amount. D. \$ _____

MARYLAND HEALTH CARE COVERAGE

See Instruction 3.

Check here If you do not have health care coverage DOB (mm/dd/yyyy)
Check here If your spouse does not have health care coverage DOB (mm/dd/yyyy)
I authorize the Comptroller of Maryland to share information from this tax return with the Maryland Health Benefit Exchange for the purpose of determining pre-eligibility for no-cost or low-cost health care coverage.
E-mail address

INCOME

See Instruction 11.

1. Adjusted gross income from your federal return 1.
1a. Wages, salaries and/or tips 1a.
1b. Earned income 1b.
1c. Capital Gain or (loss) 1c.
1d. Taxable Pensions, IRAs, Annuities (Attach Form 502R.) 1d.
1e. Place a "Y" in this box if the amount of your investment income is more than \$10,300

ADDITIONS TO MARYLAND INCOME

See Instruction 12.

2. Tax-exempt interest on state and local obligations (bonds) other than Maryland 2.
3. State retirement pickup. 3.
4. Lump sum distributions (from worksheet in Instruction 12.) 4.
5. Other additions (Enter code letter(s) from Instruction 12.) 5.
6. Total additions (Add lines 2 through 5.) 6.
7. Total federal adjusted gross income and Maryland additions (Add lines 1 and 6.) 7.

SUBTRACTIONS FROM MARYLAND INCOME

See Instruction 13.

8. Taxable refunds, credits or offsets of state and local income taxes included in line 1 8.
9. Child and dependent care expenses 9.
10a. Pension exclusion from worksheet (13A) Yourself Spouse 10a.
10b. Pension exclusion from worksheet (13E) Yourself Spouse 10b.
11. Taxable Social Security and RR benefits (Tier I, II and supplemental) included in line 1 11.
12. Income received during period of nonresidence (See Instruction 26.) 12.
13. Subtractions from attached Form 502SU 13.
14. Two-income subtraction from worksheet in Instruction 13. 14.
15. Total subtractions (Add lines 8 through 14.) 15.
16. Maryland adjusted gross income (Subtract line 15 from line 7.) 16.

DEDUCTION METHOD

See Instruction 16.

All taxpayers must select one method and check the appropriate box.
STANDARD DEDUCTION METHOD (Enter amount on line 17.)
ITEMIZED DEDUCTION METHOD (Complete lines 17a and 17b.)
17a. Total federal itemized deductions (from line 17, federal Schedule A) 17a.
17b. State and local income taxes (See Instruction 14.) 17b.
Subtract line 17b from line 17a and enter amount on line 17.
17. Deduction amount (Part-year residents see Instruction 26 (l and m).) 17.

18. Net income (Subtract line 17 from line 16.) 18.
19. Exemption amount from Exemptions area (See Instruction 10.) 19.
20. Taxable net income (Subtract line 19 from line 18.) 20.



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NAME _____

SSN _____

MARYLAND TAX COMPUTATION	21. Maryland tax (from Tax Table or Computation Worksheet Schedules I or II) 21. _____
	22. Earned income credit (EIC) (See Instruction 18.) ▶ 22. _____ <input type="checkbox"/> Check this box if you are claiming the Maryland Earned Income Credit, but do not qualify for the federal Earned Income Credit. <input type="checkbox"/> Check this box if you are claiming the Maryland Earned Income Credit with a qualifying child.
	23. Poverty level credit (See Instruction 18.) ▶ 23. _____
	24. Other income tax credits for individuals from Part AA, line 14 of Form 502CR (Attach Form 502CR.) 24. _____
	25. Business tax credits You must file this form electronically to claim business tax credits on Form 500CR.
	26. Total credits (Add lines 22 through 25.) 26. _____
	27. Maryland tax after credits (Subtract line 26 from line 21.) If less than 0, enter 0. 27. _____
	28. Local tax (See Instruction 19 for tax rates and worksheet.) Multiply line 20 by your local tax rate .0 ____ or use the Local Tax Worksheet 28. _____
29. Local earned income credit (from Local Earned Income Credit Worksheet in Instruction 19.) . . 29. _____	
30. Local poverty level credit (from Local Poverty Level Credit Worksheet in Instruction 19.) . . . 30. _____	
31. Local tax credit from Part BB, line 1 of Form 502CR (Attach Form 502CR.) 31. _____	
32. Total credits (Add lines 29 through 31.) 32. _____	
33. Local tax after credits (Subtract line 32 from line 28.) If less than 0, enter 0 33. _____	
34. Total Maryland and local tax (Add lines 27 and 33.) 34. _____	
CONTRIBUTIONS See Instruction 20.	35. Contribution to Chesapeake Bay and Endangered Species Fund ▶ 35. _____
	36. Contribution to Developmental Disabilities Services and Support Fund ▶ 36. _____
	37. Contribution to Maryland Cancer Fund. ▶ 37. _____
	38. Contribution to Fair Campaign Financing Fund ▶ 38. _____
39. Total Maryland income tax, local income tax and contributions (Add lines 34 through 38.) . 39. _____	
	40. Total Maryland and local tax withheld (Enter total from your W-2 and 1099 forms and attach if MD tax is withheld.) ▶ 40. _____
	41. 2022 estimated tax payments, amount applied from 2021 return, payment made with an extension request, and Form MW506NRS ▶ 41. _____
	42. Refundable earned income credit (from worksheet in Instruction 21) ▶ 42. _____
	43. Refundable income tax credits from Part CC, line 10 of Form 502CR (Attach Form 502CR and/or Schedule K-1 (Forms 510/511), if applicable. See Instruction 21.) 43. _____
	44. Total payments and credits (Add lines 40 through 43.) 44. _____
	45. Balance due (If line 39 is more than line 44, subtract line 44 from line 39. See Instruction 22.) ▶ 45. _____
	46. Overpayment (If line 39 is less than line 44, subtract line 39 from line 44.) ▶ 46. _____
REFUND	47. Amount of overpayment TO BE APPLIED TO 2023 ESTIMATED TAX. ▶ 47. _____
	48. Amount of overpayment TO BE REFUNDED TO YOU (Subtract line 47 from line 46.) See line 51 REFUND ▶ 48. _____
AMOUNT DUE	49. Check here <input type="checkbox"/> if you are attaching Form 502UP. Enter interest charges from line 18, _____ or for late filing _____ or homebuyer withdrawal penalty _____ ▶ 49. _____
	50. TOTAL AMOUNT DUE (Add lines 45 and 49.) IF \$1 OR MORE, PAY IN FULL WITH THIS RETURN. INCLUDE FORM PV. 50. _____



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NAME _____ SSN _____

DIRECT DEPOSIT OF REFUND (See Instruction 22.) **Verify that all account information is correct and clearly legible.** If you are requesting direct deposit of your refund, complete the following. **For Splitting Direct Deposit**, use Form 588.

▶ Check here if you authorize the State of Maryland to issue your refund by direct deposit.

▶ Check here if this refund will go to an account outside of the United States.

51a. Type of account: ▶ Checking Savings **51b.** Routing Number (9-digits) ▶ _____

51c. Account Number ▶ _____

51d. Name(s) as it appears on the bank account _____

▶ _____ Daytime telephone no. Home telephone no. ▶ _____ CODE NUMBERS (3 digits per line)

Check here if you authorize your preparer to discuss this return with us. C if you authorize your paid preparer not to file electronically. Check here if you agree to receive your 1099G Income Tax Refund statement electronically (See Instruction 24.)

Under penalties of perjury, I declare that I have examined this return, including accompanying schedules and statements and to the best of my knowledge and belief it is true, correct and complete. If prepared by a person other than taxpayer, the declaration is based on all information of which the preparer has any knowledge.

Your signature Date

Printed name of the Preparer / or Firm's name

Signature of preparer other than taxpayer **(Required by Law)**

Spouse's signature Date

Street address of preparer or Firm's address

City, State, ZIP Code + 4

▶ _____
Telephone number of preparer Preparer's PTIN **(Required by Law)**

For returns filed without payments, mail your completed return to:

Comptroller of Maryland
Revenue Administration Division
110 Carroll Street
Annapolis, MD 21411-0001

For returns filed with payments, attach check or money order to Form PV. Make checks payable to Comptroller of Maryland. Do not attach Form PV or check/money order to Form 502. Place Form PV with attached check/money order on TOP of Form 502 and mail to:

Comptroller of Maryland
Payment Processing
PO Box 8888
Annapolis, MD 21401-8888

To make an online payment, scan the QR code below and follow instructions.





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▶ Your Social Security Number ▶ Spouse's Social Security Number

Your First Name _____ MI _____

Your Last Name _____

Spouse's First Name _____ MI _____

Spouse's Last Name _____

Print Using Blue or Black Ink Only

Summary

- 1. Enter the total number checked below for Regular dependents (.....) ▶ 1. _____
- 2. Enter the total number checked below for dependents 65 or over (.....) ▶ 2. _____
- 3. Total dependent exemptions (Add lines 1 and 2 and enter the total here and on line (C) of t
Exemptions area of Form 502, 505 or 515.) 3. _____

Dependents (If a dependent listed below is age 65 or over, check both 4 and 5.)

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		

▶ 1. _____	First Name	MI _____	▶	_____	Last Name	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
▶ 2. _____	Social Security Number	Relationship	Regular	65 or over	DOB (MM/DD/YYYY) ▶ _____	
▶ 3. _____			4. _____	5. _____		



22502B150

NAME _____ SSN _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____

▶ 1. First Name _____ MI _____ ▶ Last Name _____	Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage
Social Security Number _____ Relationship _____ Regular _____ 65 or over _____	
▶ 2. _____ 3. _____ 4. _____ 5. _____	DOB (MM/DD/YYYY) ▶ _____