



195020050

\$

OR FISCAL YEAR BEGINNING \_\_\_\_\_ 2019, ENDING \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_\_\_

REQUIRED: Maryland Physical address of taxing area as of December 31, 2019 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 2019 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: \_\_\_\_\_

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
B. 65 or over Blind
C. Enter number from line 3 of Dependent Form 502B
D. Enter Total Exemptions (Add A, B and C.) Total Amount



195020150

NAME \_\_\_\_\_ SSN \_\_\_\_\_

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) > \_\_\_\_\_
Check here [ ] 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 \$3,600. . . . . [ ]

ADDITIONS TO 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 to Maryland income (Add lines 2 through 5.) . . . . . 6. \_\_\_\_\_
7. Total federal adjusted gross income and Maryland additions (Add lines 1 and 6.) . . . . . 7. \_\_\_\_\_

SUBTRACTIONS FROM 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 from Maryland income (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. \_\_\_\_\_



195020250

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. \_\_\_\_\_

Check this box if you are claiming the Maryland Earned Income Credit, but do not qualify for the federal Earned Income Credit.

23. Poverty level credit (See Instruction 18.) . . . . . ▶ 23. \_\_\_\_\_

24. Other income tax credits for individuals from Part AA, line 13 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. \_\_\_\_\_

**LOCAL TAX COMPUTATION**

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. 2019 estimated tax payments, amount applied from 2018 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 7 of Form 502CR (**Attach Form 502CR.** 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 2020 ESTIMATED TAX** ▶ 47. \_\_\_\_\_

48. Amount of overpayment **TO BE REFUNDED TO YOU**  
(Subtract line 47 from line 46.) See line 51 . . . . . **REFUND** ▶ 48. \_\_\_\_\_

49. Check here  if you are attaching Form 502UP. Enter interest charges from line 18  
of Form 502UP \_\_\_\_\_ or for late filing \_\_\_\_\_ . . . . . ▶ 49. \_\_\_\_\_

**AMOUNT DUE**

50. **TOTAL AMOUNT DUE** (Add lines 45 and 49.)  
**IF \$1 OR MORE, PAY IN FULL WITH THIS RETURN. INCLUDE FORM PV.** . . . . . 50. \_\_\_\_\_



195020350

NAME \_\_\_\_\_ SSN \_\_\_\_\_

**DIRECT DEPOSIT OF REFUND** (See Instruction 22.) Be sure the account information is correct. **For Splitting Direct Deposit**, see Form 588. If this refund will go to an account outside of the United States, then to comply with banking rules, place a "Y" in this box

▶  and see Instruction 22. For the direct deposit option, complete the following information clearly and legibly.

**51a.** Type of account: ▶  Checking  Savings

**51b.** Routing Number (9-digits) ▶ \_\_\_\_\_ **51c.** Account Number ▶ \_\_\_\_\_

▶ \_\_\_\_\_ ▶ \_\_\_\_\_  
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. Check here ▶  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 Spouse's signature Date

\_\_\_\_\_  
Printed name of the Preparer / or Firm's name

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

\_\_\_\_\_  
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



19502B050

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

Print Using Blue or Black Ink Only

Your First Name \_\_\_\_\_ MI \_\_\_\_\_  
Your Last Name \_\_\_\_\_  
Spouse's First Name \_\_\_\_\_ MI \_\_\_\_\_  
Spouse's Last Name \_\_\_\_\_

**Summary**

- 1. Enter the total number checked below for Regular dependents (4) . . . . . ▶ 1. \_\_\_\_\_
- 2. Enter the total number checked below for dependents 65 or over (5) . . . . . ▶ 2. \_\_\_\_\_
- 3. Total dependent exemptions (Add lines 1 and 2 and enter the total here and on line (C) of the 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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		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		4. _____	Regular 65 or over	DOB (MM/DD/YYYY) ▶ _____
		3. _____		5. _____		



19502B150

NAME \_\_\_\_\_ SSN \_\_\_\_\_

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

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

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

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

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

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