



245020050

\$

OR FISCAL YEAR BEGINNING \_\_\_\_\_ 2024, 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 **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, 2024 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 surviving spouse 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 2024 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: \_\_\_\_\_



245020150

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 Maryland Health Connection for the purpose of determining pre-eligibility for no-cost or low-cost health care coverage.
Check here
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 \$11,600 . . . . .

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. See instructions.) . . . . . 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. Ranger 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. See instructions.) . . . . . 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.



245020250

Name \_\_\_\_\_ SSN \_\_\_\_\_

**MARYLAND TAX COMPUTATION**

21. **Maryland tax** (from Tax Table or Computation Worksheet Schedules I or II) . . . . . 21. \_\_\_\_\_

21a. Recaptured credit from Part DD, line 1 of Form 502CR. (Attach Form 502CR) . . . . . 21a. \_\_\_\_\_

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.

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 (Add lines 21 and 21a, then subtract line 26.) 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. 2024 estimated tax payments, amount applied from 2023 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 2025 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  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. \_\_\_\_\_





24502B050

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

**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. _____	MI	▶ Last Name _____	
Social Security Number	Relationship	Regular	65 or over
▶ 2. _____	3. _____	4. <input type="checkbox"/>	5. <input type="checkbox"/>
			Check here <input type="checkbox"/> if this dependent does not have health care coverage
			DOB (MM/DD/YYYY) ▶ _____
<i>You must provide the date of birth for the individual listed.</i>			

▶ 1. _____	MI	▶ Last Name _____	
Social Security Number	Relationship	Regular	65 or over
▶ 2. _____	3. _____	4. <input type="checkbox"/>	5. <input type="checkbox"/>
			Check here <input type="checkbox"/> if this dependent does not have health care coverage
			DOB (MM/DD/YYYY) ▶ _____
<i>You must provide the date of birth for the individual listed.</i>			

▶ 1. _____	MI	▶ Last Name _____	
Social Security Number	Relationship	Regular	65 or over
▶ 2. _____	3. _____	4. <input type="checkbox"/>	5. <input type="checkbox"/>
			Check here <input type="checkbox"/> if this dependent does not have health care coverage
			DOB (MM/DD/YYYY) ▶ _____
<i>You must provide the date of birth for the individual listed.</i>			

▶ 1. _____	MI	▶ Last Name _____	
Social Security Number	Relationship	Regular	65 or over
▶ 2. _____	3. _____	4. <input type="checkbox"/>	5. <input type="checkbox"/>
			Check here <input type="checkbox"/> if this dependent does not have health care coverage
			DOB (MM/DD/YYYY) ▶ _____
<i>You must provide the date of birth for the individual listed.</i>			

▶ 1. _____	MI	▶ Last Name _____	
Social Security Number	Relationship	Regular	65 or over
▶ 2. _____	3. _____	4. <input type="checkbox"/>	5. <input type="checkbox"/>
			Check here <input type="checkbox"/> if this dependent does not have health care coverage
			DOB (MM/DD/YYYY) ▶ _____
<i>You must provide the date of birth for the individual listed.</i>			



24502B150

Name \_\_\_\_\_ SSN \_\_\_\_\_

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

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▶ 2. _____	Social Security Number	Relationship	3. _____	4. <input type="checkbox"/>	Regular	5. <input type="checkbox"/>	65 or over
Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage							
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Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage							
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Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage							
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Check here ▶ <input type="checkbox"/> if this dependent does not have health care coverage							
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<i>You must provide the date of birth for the individual listed.</i>							