STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

# PAYEE DATA RECORD

(Required when receiving payment from the State of California in lieu of IRS W-9 or W-7)

STD 204 (Rev. 4/2017)

**1**

**INSTRUCTIONS:** Type or print the information. Complete all information on this form. Sign, date, and return to the state agency (department/office) address shown in Box 6. Prompt return of this **fully completed** form will prevent delays when processing payments.

Information provided in this form will be used by California state agencies to prepare Information Returns (Form1099). See next page for more information and Privacy Statement.

**NOTE:** Governmental entities, i.e. federal, state, and local (including school districts), are not required to submit this form.

**2**

**PAYEE'S LEGAL BUSINESS NAME** *(As shown on your income tax return)*

**SOLE PROPRIETOR OR INDIVIDUAL– ENTER NAME AS SHOWN ON SSN** *(Last, First, M.I.)*

**E-MAIL ADDRESS**

| **MAILING ADDRESS** | | | **BUSINESS ADDRESS** | | |
|---|---|---|---|---|---|
| **CITY** | **STATE** | **ZIP CODE** | **CITY** | **STATE** | **ZIP CODE** |

**3**

**PAYEE ENTITY TYPE**

**CHECK ONE BOX ONLY**

**ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):** ☐☐-☐☐☐☐☐☐☐

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

**CORPORATION:**

◯ **MEDICAL** *(e.g., dentistry, psychotherapy, chiropractic, etc.)*

◯ **LEGAL** *(e.g., attorney services)*

◯ **EXEMPT** *(nonprofit)*

◯ **ALL OTHERS**

☐ **SOLE PROPRIETOR OR INDIVIDUAL**

Enter social security number (SSN) or Individual taxpayer identification number (ITIN)

☐☐☐-☐☐-☐☐☐☐

*(SSN required by authority of California Revenue and Tax Code sections 18646 and 18661)*

**NOTE:** Payment will not be processed without an accompanying taxpayer identification number.

**4**

**PAYEE RESIDENCY STATUS**

☐ **CALIFORNIA RESIDENT** - Qualified to do business in California or maintains a permanent place of business in California.

☐ **CALIFORNIA NON RESIDENT** *(see next page for more information)* - Payments to nonresidents for services may be subject to state income tax withholding.

◯ No services performed in California.

◯ Copy of Franchise Tax Board waiver of state withholding attached.

**5**

**I hereby certify under penalty of perjury that the information provided on this document is true and correct. Should my residency status change, I will promptly notify the state agency below.**

| **AUTHORIZED PAYEE REPRESENTATIVE'S NAME** *(Type or Print)* | **TITLE** | **TELEPHONE** *(include area code)* |
|---|---|---|
| **SIGNATURE** | **DATE** | **E-MAIL ADDRESS** |

**6**

**Please return completed form to:**

| **DEPARTMENT/OFFICE** | | | **UNIT/SECTION** | |
|---|---|---|---|---|
| CA DEPT OF FOOD & AGRICULTURE | | | ACCOUNTS PAYABLE | |
| **MAILING ADDRESS** | | | **TELEPHONE** *(include area code)* | **FAX** |
| 1220 N STREET, ROOM 140 | | | 916-654-0424 | 916-651-5288 |
| **CITY** | **STATE** | **ZIP CODE** | **E-MAIL ADDRESS** | |
| SACRAMENTO | CA | 95814 | | |