STATE OF CALIFORNIA - DEPARTMENT OF . INANCE

PAYEE DATA RECORD

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

STD. 204 (Revised 12/12/12)

Vendor #: _____
(for Accounting use)

1

INSTRUCTIONS: Complete all information on this form. Sign, date, and return to the State agency (department/office) address shown at the bottom of this page. Prompt return of this **fully completed** form will prevent delays when processing payments. Information provided in this form will be used by State agencies to prepare Information Returns (1099). See reverse side for more information and Privacy Statement.

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PAYEE'S LEGAL BUSINESS NAME (Type of Print)

AGREEMENT NO. 12-104

Mountains Recreation and Conservation Authority

SOLE PROPRIETOR- ENTER NAME AS SHOWN ON SSN (Last, First, M.I.)

E-MAIL ADDRESS

MAILING ADDRESS

5810 Ramirez Canyon Road

REMIT PAYMENT TO THE ADDRESS BELOW:

CITY, STATE, ZIP CODE

Malibu, CA 90265

CITY, STATE, ZIP CODE

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Please **CHECK ONE BOX** That corresponds to the **PAYEE BUSINESS TYPE**

PAYEE ENTITY TYPE (Please check one box)

☐ INDIVIDUAL OR SOLE PROPRIETOR (I)

ENTER SOCIAL SECURITY NUMBER (Required - 9 digits) ___ - __ - ____

(SSN required by authority of California Revenue and Tax Code Section 18646)

Please check one box to specify business type:

☐ PARTNERSHIP (P)

☐ ESTATE OR TRUST (E)

CORPORATION (C) :

☐ LEGAL (e.g., attorney services)

☐ EXEMPT (non-profit)

☐ ALL OTHERS

ENTER Federal Employer Identification Number (FEIN): 7 7 - 0 1 1 2 3 6 7

(Required field - 9 digits)

Please check one box and circle one - Fed Tax ID is not required for Governmental payee.

☐ FEDERAL (2)

☐ STATE, CSU & CSU TRUSTEE (3) (Please circle one)

☐ CITY or COUNTY (4) (Please circle one)

☐ School, Districts, Public Commission, Joint Powers, REGENTS / UC'S (5) (Please circle one)

☐ OTHER : _____

NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.

Note: Additional Certified as

☐ SMALL BUSINESS or DISABLED VETERAN BUSINESS ENTERPRISE (Please circle one and enter OSDS Certification

Certification No.: _____ (SBE or DVBE)

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PAYEE Residency Status

☐ California Resident - Qualified to do business in California or maintains a permanent place of business in California.

☐ California nonresident (see reverse side) - 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.

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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

SIGNATURE

DATE

TELEPHONE

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Please return completed form to:

Department/Office: STATE COASTAL CONSERVANCY

Mailing Address: 1330 BROADWAY, 13th FLOOR

City/State/Zip: OAKLAND, CA 94612-2530

Telephone: 510-286-1015 **Fax:**

E-mail Address: