RFA: #17-10072 Date: 04/27/2017

Form 6

STATE OF CALIFORNIA-DEPARTMENT OF FINANCE

## **PAYEE DATA RECORD**

(Required when receiving payment from the State of California in lieu of IRS W-9) STD. 204 (Rev. 6-2003)

		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 <b>fully completed</b> 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.  NOTE: Governmental entitles, federal, State, and local (including school districts), are not required to submit this form.  PAYEE'S LEGAL BUSINESS NAME (Type or Print)						
			COUNTY OF MENDOCINO					
		2	SOLE PROPRIETOR - ENTER NAME AS SHOWN ON SSN (La		st, First, M.I.)	E-MAIL ADDRESS		
			MAILING ADDR	RESS	ESS BUSINESS ADDRESS			
				P RD, RM 1080	SAME	TEO O	*	
		CITY, STATE, 2						
				AH, CA 95482 SAME			II.	
	PA EN T	3 AYEE ITITY YPE	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN):    9   4   -   6   0   0   0   5   2   0				NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.	
ON		E BOX NLY		INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:  (SSN required by authority of California Revenue and Tax Code Section 18646)				
	RESI	AYEE DENCY ATUS	<ul> <li>✓ California resident - Qualified to do business in California or maintains a permanent place of business in California.</li> <li>California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding.</li> <li>No services performed in California.</li> <li>Copy of Franchise Tax Board waiver of State withholding attached.</li> </ul>					
Should my residency status change				Should my residency status change,	nformation provided on this document is true and correct.  I will promptly notify the State agency below.			
		a jin a aya		PAYEE REPRESENTATIVE'S NAME (Type or Pr	int)	TITLE		
			LUCY SIMON		ASST AUDITOR-CO		JNTROLLER	
			SIGNATURE	\(\frac{1}{2}\)	DATE 05/19/2016	(707) 234-6860		
6	Please return completed form to:							
Unit/Se		Departr	nent/Office:	California Department of Public Health				
		Unit/Se	ction:	Immunization Branch				
		Mailing	Address: 850 Marina Bay Parkway, Bldg. P, 2 <sup>nd</sup> Floor					
City/S		City/Sta	ite/ZIP:	ZIP: Richmond, CA 94804				
Teleph		Telepho	one:	(510) 620-3737 <b>FAX</b> : (510) 620-3774				