State of California—Department of Health Services

PAYEE DATA RECORD

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

STD. 204 (Rev. 6-2003)

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.

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

2

PAYEE'S LEGAL BUSINESS NAME (Type or Print): SIERRA INFORMATION SERVICES

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

E-MAIL ADDRESS: SIERRAINFO@AOL.COM

MAILING ADDRESS: 19229 SONOMA HWY #264

BUSINESS ADDRESS: 19229 SONOMA HWY #264

CITY, STATE, ZIP CODE: SONOMA CA 95476

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PAYEE ENTITY TYPE

CHECK ONE BOX ONLY

ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): 94-3199501

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

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION:

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

☐ **LEGAL** (e.g., attorney services)

☐ **EXEMPT** (nonprofit)

☒ **ALL OTHERS**

☐ **INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER:** ___ - __ - ____

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

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PAYEE RESIDENCY TYPE

☒ 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): ANDREW H. KARP

TITLE: PRESIDENT

SIGNATURE: Andrew H Karp

DATE: 3/4/04

TELEPHONE: (707) 996 7380

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Please return completed form to:

Department/Office: _____

Unit/Section: _____

Mailing Address: _____

City/State/ZIP: _____

Telephone: ( ) _____ **FAX:** ( ) _____

E-Mail Address: _____