CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY (CHFFA) & CALIFORNIA DEPARTMENT OF HEALTH CARE ACCESS AND INFORMATION (HCAI)

Distressed Hospital Loan Program Application

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Sacramento, California 95814
Phone: (916) 653-2799
chffa@treasurer.ca.gov
http://www.treasurer.ca.gov/chffa/

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Form No. CHFFA 13 DHLP-01 (05/2023)

General Information and Instructions

The Distressed Hospital Loan Program offers interest-free cashflow loans to not-for-profit and public hospitals in significant financial distress or to governmental entities representing a closed hospital to prevent the closure of, or facilitate the reopening of, those hospitals in accordance with Health and Safety Code sections 129380 through 129387. The Department of Health Care Access and Information administers the Distressed Hospital Loan Program, which is implemented in consultation with the California Health Facilities Financing Authority under Health and Safety Code sections 129382 and 129383.

In order to be considered for a loan under the first funding round of the Distressed Hospital Loan Program, a **complete** application must be submitted to the California Health Facilities Financing Authority **by no later than 5:00pm Pacific Time (PT) on July 31, 2023**.

If a hospital would like the Department of Health Care Access and Information to conduct a preliminary review of a hospital's eligibility and determine the hospital's eligibility prior to the hospital spending resources on developing a Turnaround Plan, an applicant must submit its application with all items except the Turnaround Plan by no later than 5:00pm (PT) on June 30, 2023.

Submit a complete application to the California Health Facilities Financing Authority by email as a Portable Document Format (PDF) attachment to chffa@treasurer.ca.gov. Attach additional pages to the application if necessary to respond to any of the requirements. ***Please Note:*** *The California Health Facilities Financing Authority is not responsible for email transmittal delays or failures of any kind.*

The Department of Health Care Access and Information will review loan applications as they are received. If the Department of Health Care Access and Information determines that an eligible hospital is in danger of closure prior to the funding round deadline, the Department of Health Care Access and Information may take necessary actions to issue a small bridge loan to assist the hospital until the funding round is closed and final loan determinations are made.

Funding is limited, and loans may be awarded based on the hospital's Turnaround Plan and community need, among other factors in the evaluation methodology posted on the Department of Health Care Access and Information's website: https://hcai.ca.gov/construction-finance/distressed-

hospital-loan-program/. Any remaining funds after the first funding round may be available in subsequent funding rounds, and a notice of subsequent funding rounds will be posted on the California Health Facilities Financing Authority's website.

Loan Terms and Conditions

Applicants approved for a loan under the Distressed Hospital Loan Program will be required to execute a Loan and Security Agreement and a Promissory Note. The Loan and Security Agreement will include ongoing compliance requirements, such as quarterly and annual submission of financial statements, budgets, Turnaround Plan progress reports, utilization statistics, and various financial ratios.

Pursuant to Health and Safety Code section 129384, subdivision (b), security for the loans shall be Medi-Cal reimbursements due to the hospital from the State Department of Health Care Services. The California Health Facilities Finance Authority may intercept an amount not to exceed twenty percent (20%) of the hospital's respective Medi-Cal checkwrite payments until the loan has been satisfied. In the event that a twenty percent (20%) withhold will not result in full repayment of the loan within a 72-month period, the Department of Health Care Access and Information may extend the repayment term of the loan.

SECTION ONE: SUMMARY INFORMATION

APPLICANT INFORMATION:		
Legal Name (Include DBA Name)		
Street Address	**Federal Tax I.D. Number**	
City, State & Zip	**Contact Person / Title**	
County	**Telephone Number**	**Email Address**
Type of Entity (as defined in Health and Safety Code section 129381): ☐ Not-for profit Hospital ☐ Public Hospital		
NOTE: Not-for-profit and public hospitals that belong to integrated health care systems with more than two separately licensed hospital facilities are ineligible under Health and Safety Code section 129383, subdivision (e).		
LOAN INFORMATION:		
Amount Requested: $		
Provide a high-level explanation of how loan proceeds will be used for the purposes of preventing the closure, or facilitating the reopening, of the hospital, summarizing any preliminary projections and strategies for regaining financial viability (this should not be the full Turnaround Plan):		

SECTION TWO: FINANCIAL STANDING

1. **Financial Ratios:** Calculate the hospital's financial ratios, including:

   a) Days Cash on Hand:
   Days Cash on Hand = unrestricted cash and cash equivalents ÷ [(operating expenses – non-cash charges) ÷ 365 days]

   b) Current Ratio:
   Current Ratio = (Current Assets ÷ Current Liabilities)

   c) Operating Margin:

   Operating Margin = (Net Income ÷ Total Revenue)

   d) Net Cash Runway:

   Net Cash Runway = Cash Balance ÷ Monthly Average Operating Loss (excluding depreciation and non-cash expenses)

   e) Debt Service Coverage (Net):
   Debt Service Coverage Ratio = Net Income Available for Debt Service* ÷ Actual Annual Debt Service

   * Net Income Available for Debt Service = Excess of Revenue Over Expenses + Depreciation Expense + Amortization Expense + Interest Expense + Non-Cash Charges – Restricted Donations – Extraordinary/Non-Recurring Charge – Non-Cash Revenues – Unrealized Gain (Loss) on Investments

2. Describe any material changes in revenue, expenses, assets, and liabilities over the last full audited fiscal year and fiscal year-to-date.

3. Describe any attempts that the hospital has made to secure lines of credit or other working capital. Describe the outcome of those attempts and if the attempts were successful, unsuccessful, or not economically viable.

4. Is the hospital in technical or payment default with any long-term debt covenants? Please include whether the lender is implementing remedies of default actions.

5. Has the hospital already pledged Medi-Cal revenues to any lender or creditor, which would result in the Medi-Cal revenue collateral for the Distressed Hospital Loan Program to be subordinate to the existing loan or lien? If so, provide the name of the lender or creditor and the purpose of the loan or lien.

SECTION THREE: COMMUNITY NEED/BENEFIT STATEMENT

1. Describe how the closure of the hospital would impact or has impacted the health care needs of the community or of underserved populations.

2. What is the access to health care impact for the provider network and service offerings in the community if the hospital were to close, or what is such an impact after closure? Also describe the distance (in miles) to the nearest hospital and outpatient services, as well as the name of the nearest hospital and outpatient services and the types of services that they offer.

3. Is the hospital located in one of the following Medical Service Study Area designations? (Verify location designation)

   a. Medically Underserved Area (MUA) Yes__ No__
   b. Medically Underserved Population (MUP) Yes__ No__

SECTION FOUR: PAYOR MIX & UTILIZATION TABLES

1. For the two most recently completed fiscal years, provide the percentage of each revenue source (Medi-Cal, Medicare, private insurance, etc.).

Revenue Source	**% of Total Revenue** For *Fiscal Year* **20**	**20**
Medi-Cal (including Managed Medi-Cal)		
Medicare (including Managed Medicare)		
Commercial (private insurance)		
Self-pay		
Charity & Unreimbursed Care		
Total:	**100%**	**100%**

2. For the last five fiscal years and year-to-date, provide the following:

	2018	**2019**	**2020**	**2021**	**2022**	**2023 YTD**
Average Daily Census						

	2018	**2019**	**2020**	**2021**	**2022**	**2023 YTD**
Inpatient Visits						
Outpatient Visits (Hosp)						
Outpatient Visits (Clinic)						
Emergency Visits						

SECTION FIVE: LEGAL STATUS QUESTIONNAIRE

1. Financial Viability

   Disclose material information relating to any legal or regulatory proceeding or investigation in which the applicant/borrower/project sponsor is or has been a party and which might have a material impact on the financial viability of the project or the applicant/borrower/project sponsor. Such disclosures should include any parent, subsidiary, or affiliate of the applicant/borrower/project sponsor that is involved in the management, operation, or development of the project.

   Response:

2. Fraud, Corruption, or Serious Harm

   Disclose any civil, criminal, or regulatory action in which the applicant/borrower/project sponsor, or any current board members (not including volunteer board members of non-profit entities), partners, limited liability corporation members, senior officers, or senior management personnel has been named a defendant in such action in the past ten years involving fraud or corruption, matters related to employment conditions (including, but not limited to wage claims, discrimination, or harassment), or matters involving health and safety where there are allegations of serious harm to employees, the public or the environment.

   Response:

Disclosures should include civil or criminal cases filed in state or federal court; civil or criminal investigations by local, state, or federal law enforcement authorities; and enforcement proceedings or investigations by local, state or federal regulatory agencies. The information provided must include relevant dates; the nature of the allegation(s), charges, complaint or filing; and the outcome.

Provide the following supplemental attachments:

Attachments A – Financial Information

1. Provide a copy of audited financial statements for the most recent fiscal year.
2. Provide a copy of internally prepared year-to-date unaudited financial statements for the current year.
3. Complete and provide the Fi$Cal Form (for government agencies, Exhibit B) or STD 204 (for not-for-profit hospitals, Exhibit C)

Attachments B – Management/Organization Information

1. Provide the most recent board meeting minutes/packet.
2. Provide the current operating license for the hospital.
3. Provide the organization's articles of incorporation/bylaws, if applicable.
4. Provide the most recent and complete IRS Form 990.
5. If applicable, complete and provide a copy of the applicant's board resolution approving/ratifying the submission of the application and authorizing the execution of loan documents and additional indebtedness (Exhibit A).

   Note: This resolution may be completed and submitted at the time of or after application submittal, but it is required for loan disbursement.

Attachment C - Turnaround Plan[1]

An applicant may submit its application without a Turnaround Plan; however, prior to consideration for loan approval, the applicant must provide a Turnaround Plan, which must include projections detailing the uses of the proposed loan and strategies proposed by the hospital's governing body to regain financial viability to continue to operate. Turnaround Plan must include:

a) A 24-month cash-flow projection of current financial situation.

b) Narrative describing actions being taken or to be taken by leadership including whether to cut or eliminate any services.

c) A 24-month cash-flow projection of future financial situation that incorporates the actions taken by leadership and identifies how the loan proceeds will be utilized and repaid after the 18-month grace period.

d) A description of how actions will affect various revenue and expense line items.

[1] Prior to dedicating financial and labor resources to create a Turnaround Plan, applicants are encouraged to submit all application questions and data submittal items without the Turnaround Plan for a preliminary review by HCAI's staff. Please see General Information and Instructions for deadlines.

APPLICATION CERTIFICATION

An individual with the authority to bind the applicant to an agreement with the State of California, if a loan under the Distressed Hospital Loan Program is approved for the applicant, must complete the following certification:

I certify that, to the best of my knowledge, the information contained in this application and the accompanying supplemental materials submitted by the applicant for a loan under the Distressed Hospital Loan Program are true and accurate. I understand that if the applicant is approved for a loan under the Distressed Hospital Loan Program, the applicant will be required to enter into a Loan and Security Agreement with the State of California and execute a Promissory Note, as well as provide any additional information or documentation that may be required for loan disbursement. I further understand that misrepresentation or inaccurate information or documentation provided by the applicant may result in the cancellation of the loan, if approved, and that the State of California is authorized to take any additional actions as may be provided under the laws of the State of California.

_____	_____
By (Print Name)	Signature
_____	_____
Title	Date

Checklist – Distressed Hospital Loan Program Application

Please use this checklist to determine if the application is complete.

Section One: Summary Information

(Page 2) ☐ - Completed Applicant Information & Loan Information sections.

Section Two: Financial Standing

(Page 3) ☐ - Provided Financial Ratio calculations.

☐ - Provided and completed a management report of any material changes in revenue, expenses, assets, and liabilities over the last full audited fiscal year and fiscal year-to-date.

☐ - Provided description of attempts to secure lines of credit or other working capital.

☐ - Described if the hospital was in technical or payment default.

☐ - Described if the hospital has already pledged Medi-Cal revenues.

Section Three: Community Need/Benefit Statement

(Page 4) ☐ - Described how the closure of the hospital would impact or has impacted the health care needs of the community or of underserved populations.

☐ - Described the access to health care impact for the provider network and service offerings in the community if the hospital were to close and to the nearest hospital.

☐ - Completed Medical Service Study Area designations.

Section Four: Payor Mix & Utilization Tables

(Page 4) ☐ - Completed Payor Mix Table.

☐ - Completed Utilization Table.

Section Five: Legal Status Questionnaire

(Page 5) ☐ - Completed Legal Status Questionnaire (with an explanation for all "yes" answers).

Attachments A – Financial Information

☐ - Provided a copy of audited financial statements for the most recent fiscal year.

☐ - Provided a copy of internally prepared year-to-date unaudited financial statements for the current year.

☐ - Provided a completed copy of the Fi$Cal Form (Exhibit B) **or** Form STD 204 (Exhibit C).

Attachments B – Management/Organization Information

☐ - Provided the most recent board meeting minutes/packet.

☐ - Provided the current operating license for the hospital.

☐ - Provided the articles of incorporation/bylaws, if applicable.

☐ - Provided the most recent and complete IRS Form 990.

☐ - Provided copy of applicant's board resolution (Exhibit A), if applicable. **Note:** This resolution may be completed and submitted at the time of or after application submittal, but it is required for loan disbursement.

Attachment C – Turnaround Plan

☐ - Provided a complete Turnaround Plan.

Application Certification

☐ - Executed Application Certification.

Exhibit A – Applicant's Board Resolution

RESOLUTION NO. xx-xx
RESOLUTION OF {**BORROWER NAME**} AUTHORIZING EXECUTION AND DELIVERY OF A PROMISSORY NOTE, LOAN AND SECURITY AGREEMENT, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR A LOAN UNDER THE DISTRESSED HOSPITAL LOAN PROGRAM

DISTRESSED HOSPITAL LOAN PROGRAM

WHEREAS, {**Borrower Name**} (the "Borrower") is a **{not-for-profit hospital, or a public hospital}**, as defined in Section 129381 of the Health and Safety Code;

WHEREAS, Borrower does not belong to an integrated health care system with more than two separately licensed hospital facilities.

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed **$0,000,000.00** from the California Health Facilities Financing Authority (the "Lender") under the Distressed Hospital Loan Program, with that loan to be funded with the proceeds in the Distressed Hospital Loan Program Fund; and

WHEREAS, the Borrower intends to use the loan in order to **{prevent the closure of/ or facilitate the reopening of}** the hospital;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby **{approves/ratifies}** the submission of an application for a loan from the Distressed Hospital Loan Program.

Section 2. {**NAME(s), TITLE(s) OF AUTHORIZED OFFICER(s)**} ({each} an "Authorized Officer") is{are} hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan, is hereby approved. The loan shall be in a principal amount not to exceed **$0,000,000.00,** shall not bear interest, and shall mature 72 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The {Each} Authorized Officer(s) is (are) hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially that form, which includes the Loan Funds Disbursement Certification, as well as the redirection of up to twenty percent (20%) of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default in accordance with Health and Safety Code section 129384, with those changes therein as the Authorized Officer(s) may require or approve, that approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with those changes therein as the Authorized Officer(s) may require or approve, that approval to be conclusively evidenced by the execution and delivery thereof.

PASSED AND ADOPTED at a regular meeting of the Board of Directors of {**Borrower Name**} held on the xx day of {**Month, Year**}.

SAMPLE

SECRETARY'S CERTIFICATE

I, _____**,** Secretary of {**BORROWER NAME**}**,** hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of {**BORROWER NAME**} duly and regularly held at the regular meeting place thereof on the _____ day of _____, 20___**,** of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

Ayes:

Noes:

Absent:

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

_____
Secretary

Date: _____

Exhibit B – Fi$Cal Form (for Government Agencies)

State of California
Financial Information System for California (FI$Cal)

GOVERNMENT AGENCY TAXPAYER ID FORM

2000 Evergreen Street, Suite 215
Sacramento, CA 95815
www.fiscal.ca.gov
1-855-347-2250

The principal purpose of the information provided is to establish the unique identification of the government entity.

Instructions: You may submit one form for the principal government agency and all subsidiaries sharing the same TIN. Subsidiaries with a different TIN must submit a separate form. Fields marked with an asterisk (*) are required. Hover over fields to view help information. Please print the form to sign prior to submittal. You may email the form to: vendors@fiscal.ca.gov, or fax it to (916) 576-5200, or mail it to the address above.

Principal Government Agency Name*

Remit-To Address (Street or PO Box)*

City* State * Zip Code*+4

Government Type:
- ☐ City
- ☐ County
- ☐ Special District
- ☐ Federal
- ☐ Other (Specify)

Federal Employer Identification Number (FEIN)*

List other subsidiary Departments, Divisions or Units under your principal agency's jurisdiction who share the same FEIN and receives payment from the State of California.

Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address
Dept/Division/Unit Name	Complete Address

Contact Person* Title

Phone number* E-mail address

Signature* Date

Exhibit C – Form STD 204 (for Not-for-profit Hospitals)

Link to pdf fillable version of form

Print Form Reset Form

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. 03/2021)

Section 1 – Payee Information

NAME (This is required. Do not leave this line blank. Must match the payee's federal tax return)

BUSINESS NAME, DBA NAME or DISREGARDED SINGLE MEMBER LLC NAME (If different from above)

MAILING ADDRESS (number, street, apt. or suite no.) (See instructions on Page 2)

CITY, STATE, ZIP CODE	**E-MAIL ADDRESS**

Section 2 – Entity Type

Check one (1) box only that matches the entity type of the Payee listed in Section 1 above. (See instructions on page 2)

☐ **SOLE PROPRIETOR / INDIVIDUAL**

☐ **SINGLE MEMBER LLC** *Disregarded Entity owned by an individual*

☐ **PARTNERSHIP**

☐ **ESTATE OR TRUST**

CORPORATION (see instructions on page 2)

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

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

☐ **EXEMPT** *(e.g., nonprofit)*

☐ **ALL OTHERS**

Section 3 – Tax Identification Number

Enter your Tax Identification Number (TIN) in the appropriate box. The TIN must **match** the name given in Section 1 of this form. Do not provide more than one (1) TIN. The TIN is a 9-digit number. **Note:** Payment will not be processed without a TIN.

- For **Individuals**, enter SSN.
- If you are a **Resident Alien**, and you do not have and are not eligible to get an SSN, enter your ITIN.
- Grantor Trusts (such as a Revocable Living Trust while the grantors are alive) may not have a separate FEIN. Those trusts must enter the individual grantor's SSN.
- For **Sole Proprietor or Single Member LLC (disregarded entity), in which the sole member is an individual**, enter SSN (ITIN if applicable) or FEIN (FTB prefers SSN).
- For **Single Member LLC (disregarded entity), in which the sole member is a business entity**, enter the owner entity's FEIN. Do not use the disregarded entity's FEIN.
- For all other entities including LLC that is taxed as a corporation or partnership, estates/trusts (with FEINs), enter the entity's FEIN.

Social Security Number (SSN) or Individual Tax Identification Number (ITIN)

___ ___ ___ -___ ___ - ___ ___ ___ ___

OR

Federal Employer Identification Number (FEIN)

___ ___ - ___ ___ ___ ___ ___ ___ ___

Section 4 – Payee Residency Status (See instructions)

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

☐ **CALIFORNIA NONRESIDENT** – 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 is attached.

Section 5 – Certification

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.

NAME OF AUTHORIZED PAYEE REPRESENTATIVE	**TITLE**	**E-MAIL ADDRESS**
SIGNATURE	**DATE**	**TELEPHONE** *(include area code)*

Section 6 – Paying State Agency

Please return completed form to:

STATE AGENCY/DEPARTMENT OFFICE		**UNIT/SECTION**	
MAILING ADDRESS		**FAX**	**TELEPHONE** *(include area code)*
CITY	**STATE**	**ZIP CODE**	**E-MAIL ADDRESS**

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. 03/2021)

GENERAL INSTRUCTIONS

Type or print the information on the Payee Data Record, STD 204 form. Sign, date, and return to the state agency/department office address shown in Section 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/departments to prepare Information Returns (Form1099).
NOTE: Completion of this form is optional for Government entities, i.e. federal, state, local, and special districts.

A completed Payee Data Record, STD 204 form, is required for all payees (non-governmental entities or individuals) entering into a transaction that may lead to a payment from the state. Each state agency requires a completed, signed, and dated STD 204 on file; therefore, it is possible for you to receive this form from multiple state agencies with which you do business.

Payees who do not wish to complete the STD 204 may elect not to do business with the state. If the payee does not complete the STD 204 and the required payee data is not otherwise provided, payment may be reduced for federal and state backup withholding. Amounts reported on Information Returns (Form 1099) are in accordance with the Internal Revenue Code (IRC) and the California Revenue and Taxation Code (R&TC).

Section 1 – Payee Information

Name – Enter the name that appears on the payee's federal tax return. The name provided shall be the tax liable party and is subject to IRS TIN matching (when applicable).

- Sole Proprietor/Individual/Revocable Trusts – enter the name shown on your federal tax return.
- Single Member Limited Liability Companies (LLCs) that is disregarded as an entity separate from its owner for federal tax purposes - enter the name of the individual or business entity that is tax liable for the business in section 1. Enter the DBA, LLC name, trade, or fictitious name under Business Name.
- Note: for the State of California tax purposes, a Single Member LLC is not disregarded from its owner, even if they may be disregarded at the Federal level.
- Partnerships, Estates/Trusts, or Corporations – enter the entity name as shown on the entity's federal tax return. The name provided in Section 1 must match to the TIN provided in section 3. Enter any DBA, trade, or fictitious business names under Business Name.

Business Name – Enter the business name, DBA name, trade or fictitious name, or disregarded LLC name.
Mailing Address – The mailing address is the address where the payee will receive information returns. Use form STD 205, Payee Data Record Supplement to provide a remittance address if different from the mailing address for information returns, or make subsequent changes to the remittance address.

Section 2 – Entity Type

If the Payee in Section 1 is a(n)…	THEN Select the Box for…
Individual ● Sole Proprietorship ● Grantor (Revocable Living) Trust disregarded for federal tax purposes	Sole Proprietor/Individual
Limited Liability Company (LLC) owned by an individual and is disregarded for federal tax purposes	Single Member LLC-owned by an individual
Partnerships ● Limited Liability Partnerships (LLP) ● and, LLC treated as a Partnership	Partnerships
Estate ● Trust (other than disregarded Grantor Trust)	Estate or Trust
Corporation that is medical in nature (e.g., medical and healthcare services, physician care, nursery care, dentistry, etc. ● LLC that is to be taxed like a Corporation and is medical in nature	Corporation-Medical
Corporation that is legal in nature (e.g., services of attorneys, arbitrators, notary publics involving legal or law related matters, etc.) ● LLC that is to be taxed like a Corporation and is legal in nature	Corporation-Legal
Corporation that qualifies for an Exempt status, including 501(c) 3 and domestic non-profit corporations.	Corporation-Exempt
Corporation that does not meet the qualifications of any of the other corporation types listed above ● LLC that is to be taxed as a Corporation and does not meet any of the other corporation types listed above	Corporation-All Other

Section 3 – Tax Identification Number

The State of California requires that all parties entering into business transactions that may lead to payment(s) from the state provide their Taxpayer Identification Number (TIN). The TIN is required by R&TC sections 18646 and 18661 to facilitate tax compliance enforcement activities and preparation of Form 1099 and other information returns as required by the IRC section 6109(a) and R&TC section 18662 and its regulations.

Section 4 – Payee Residency Status

Are you a California resident or nonresident?

- A corporation will be defined as a "resident" if it has a permanent place of business in California or is qualified through the Secretary of State to do business in California.
- A partnership is considered a resident partnership if it has a permanent place of business in California.
- An estate is a resident if the decedent was a California resident at time of death.
- A trust is a resident if at least one trustee is a California resident.
  - For individuals and sole proprietors, the term "resident" includes every individual who is in California for other than a temporary or transitory purpose and any individual domiciled in California who is absent for a temporary or transitory purpose. Generally, an individual who comes to California for a purpose that will extend over a long or indefinite period will be considered a resident. However, an individual who comes to perform a particular contract of short duration will be considered a nonresident.

For information on Nonresident Withholding, contact the Franchise Tax Board at the numbers listed below:

Withholding Services and Compliance Section: 1-888-792-4900 E-mail address: wscs.gen@ftb.ca.gov
For hearing impaired with TDD, call: 1-800-822-6268 Website: www.ftb.ca.gov

Section 5 – Certification

Provide the name, title, email address, signature, and telephone number of individual completing this form and date completed. In the event that a SSN or ITIN is provided, the individual identified as the tax liable party must certify the form. Note: the signee may differ from the tax liable party in this situation if the signee can provide a power of attorney documented for the individual.

Section 6 – Paying State Agency

This section must be completed by the state agency/department requesting the STD 204.

Privacy Statement

Section 7(b) of the Privacy Act of 1974 (Public Law 93-579) requires that any federal, state, or local governmental agency, which requests an individual to disclose their social security account number, shall inform that individual whether that disclosure is mandatory or voluntary, by which statutory or other authority such number is solicited, and what uses will be made of it. It is mandatory to furnish the information requested. Federal law requires that payment for which the requested information is not provided is subject to federal backup withholding and state law imposes noncompliance penalties of up to $20,000. You have the right to access records containing your personal information, such as your SSN. To exercise that right, please contact the business services unit or the accounts payable unit of the state agency(ies) with which you transact that business.

All questions should be referred to the requesting state agency listed on the bottom front of this form.