



CALIFORNIA DEPARTMENT OF
FOOD & AGRICULTURE
Karen Ross, Secretary

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February 10, 2017

SAN JOAQUIN COUNTY

TO: ALL COUNTY AGRICULTURAL COMMISSIONERS
ACCREDITED CERTIFYING AGENTS OPERATING IN CALIFORNIA
ALL CALIFORNIA ORGANIC REGISTRANTS

RE: **NATIONAL ORGANIC CERTIFICATION COST SHARE PROGRAM**
NEW APPLICATION PACKET FOR THE PERIOD 2016/2017

The Farm Service Agency (FSA), on behalf of the Commodity Credit Corporation (CCC) has announced the availability of funding for the fiscal year (FY) 2017 for the Organic Certification Cost Share Program (OCCSP) for eligible certified organic and transitional producers and handlers to assist with the cost of organic certification under the National Organic Certification Cost Share Program.

The California Department of Food and Agriculture (CDFA) will be distributing reimbursement to operations that have been certified or are receiving transitional certification by a USDA accredited certifying agent, and for registration fees paid to the CDFA State Organic Program (SOP) and/or the California Department of Public Health (CDPH). In addition, beginning March 20, 2017, applicants may now apply in person at any California office of the Farm Service Agency. More information is available at <https://www.fsa.usda.gov/programs-and-services/occsp/index>.

The National Organic Program (NOP) currently recognizes four scopes of certification: crops, wild crops, livestock, and processing/handling. In addition to these four scopes, applications will be accepted for reimbursement of transitional certifications and SOP/CDPH registration fees. Eligible entities will be reimbursed up to 75 percent of their organic certification costs, transitional certification costs, and SOP/CDPH fees; not to exceed \$750 per scope. Any organic operation in California that has received or renewed organic certification and SOP/CDPH registration on or between **October 1, 2016 and September 30, 2017** may apply for reimbursement. **Applications must be postmarked no later than October 31, 2017. There will be no exceptions.**

Certification/Transitional Certification Reimbursement

In order to receive certification/transitional certification reimbursement, applicants must submit a **completed Federal Organic Certification/Transitional Certification Cost Share Application (ORG-106), a copy of your certification, copies of associated paid expense invoices required to obtain and/or maintain certification, and a completed Payee Data Record Form (STD 204).**

Organic Registration Reimbursement

In order to receive State Organic Registration//Department of Health Services Registration reimbursement, **applicants must submit a completed State Organic Program/Department of Health Services Cost Share Application (ORG-106a), a copy of your current registration certificate, proof of payment of registration fees, and a completed Payee Data Record Form (STD 204).**

Applications will be processed on a first come, first serve basis. Incomplete or inaccurate applications will be returned and must be resubmitted. **Please review the Instructions page included with this application packet before completing the applications.**

See reverse side for mailing instructions, on-line link, and contact information.




Submit completed applications to:

Department of Food and Agriculture
Organic Cost Share Program
ATTN: Sharon Parsons
1220 N Street
Sacramento, CA 95814
sparsons@cdfa.ca.gov

Electronic copies of this letter and supporting material can be found at the following Internet address:
http://www.cdfa.ca.gov/is/i_&_c/organic.html under Cost Share Application. For additional information,
please contact Sharon Parsons at (916) 900-5202 or by e-mail at sparsons@cdfa.ca.gov.

Sincerely,


Sharon Parsons
Program Coordinator
California Organic Cost Share Program
Enclosures



California Department of Food and Agriculture Federal Organic Certification/Transitional Certification Cost Share Application

To be eligible for reimbursement the operation must have received or renewed organic certification on or between **October 1, 2016 and September 30, 2017**. The amount of reimbursement is 75% of certification costs (maximum of \$750) per scope of activity.
NOTE: You must send, e-mail or fax a copy of your certificate from your certifier, billing, proof of payment and Payee Data Record with your application. Applications without signatures will not be accepted. Applications must be postmarked no later than October 31, 2017. (NO EXCEPTIONS)

THIS APPLICATION IS FOR: CERTIFICATION _____ or TRANSITIONAL CERTIFICATION _____
California Department of Food and Agriculture Organic Registration Number (if applicable) _____
Are you registered with the Department of Public Health? Yes ___ No ___ Registration # _____

COMPANY INFORMATION			
Payee Name (Check will be payable to or DBA)		Company Name	
Mailing Address (Check to be mailed to)			
City	State	Zip Code	Primary County of Operation
Primary Phone Number		Alternate Phone Number	
Fax Number		E-mail Address	
CERTIFICATION INFORMATION			
Name of Certification Agency		Certification Number/Client Code	
Current Date of Certification/Certificate Issued	Application Fee (New Certifications for this Period Only) \$	Annual Certification/Recertification Fee Paid \$	
Inspection Fees Paid \$	Total Amount of Fees Paid for Certification \$		
Scope of Certification (Please check all that apply)			
<input type="checkbox"/> Crops	<input type="checkbox"/> Wild Crops	<input type="checkbox"/> Livestock	<input type="checkbox"/> Processing/Handling
Operation Types for this Certification (Check all that apply)			
<input type="checkbox"/> Producer	<input type="checkbox"/> Handler	<input type="checkbox"/> Processor	<input type="checkbox"/> Retailer
SIGNATURE			
Certification By Registrant:			
I certify that the above information is true and correct, and the operation stated above received organic certification or renewal on or between October 1, 2016 and September 30, 2017 .			
<i>Penalty for knowingly making false statements or false entries, or attempts to secure money through fraudulent means, may include fines and/or incarceration and/or forfeiture of agriculture assistance funds under applicable federal and state law.</i>			
_____		Date ____/____/____	
Certified Operations Signature		month day year	
For Official Use Only			
Organic ID/Batch Number		Total Reimbursable Amount \$	
Approved By			Date
Mail or e-mail Application and Supporting Documents To: California Department of Food and Agriculture Organic Program/Cost Share Reimbursement 1220 N Street Sacramento, CA 95814 ATTN: Sharon Parsons e-mail: sparsons@cdfa.ca.gov			



California Department of Food and Agriculture State Organic Program/Department of Health Services Cost Share Application

To be eligible for reimbursement the operation must have received or renewed organic registration on or between **October 1, 2016 and September 30, 2017**. The amount of reimbursement is 75% of registration costs (maximum of \$750).

NOTE: You must send, e-mail or fax a copy of your certificate of registration from the CA Department of Food & Agriculture or CA Department of Health Services, billing, proof of payment and Payee Data Record with your application. Applications without signatures will not be accepted. Applications must be postmarked no later than October 31, 2017. (NO EXCEPTIONS)

California Department of Food and Agriculture Organic Registration Number (if applicable) _____
 Are you registered with the Department of Public Health? Yes ___ No ___ License # _____

COMPANY INFORMATION			
Payee Name (Check will be payable to or DBA)	Company Name		
Mailing Address (Check to be mailed to)			
City	State	Zip Code	Primary County of Operation
Primary Phone Number	Alternate Phone Number		
Fax Number	E-mail Address		
REGISTRATION INFORMATION			
Name of Registration Agency (Dept. of Food & Ag or Dept. of Health Services)	Registration or License Number		
Expiration Date	Registration Fee Paid (DO NOT include Late Fees or Interest Fees) \$		
Operation Types for this Registration (Check all that apply) <input type="checkbox"/> Producer <input type="checkbox"/> Handler <input type="checkbox"/> Processor			
SIGNATURE			
Certification By Registrant: I certify that the above information is true and correct, and the operation stated above received organic registration or renewal on or between October 1, 2016 and September 30, 2017 . <i>Penalty for knowingly making false statements or false entries, or attempts to secure money through fraudulent means, may include fines and/or incarceration and/or forfeiture of agriculture assistance funds under applicable federal and state law.</i>			
_____	Date ____/____/____ month day year		
FOR OFFICIAL USE ONLY			
Mail, e-mail or fax Application and Supporting Documents To: California Department of Food and Agriculture Organic Program/Cost Share Reimbursement 1220 N Street Sacramento, CA 95814 Attn: Sharon Parsons e-mail: sparsons@cdfa.ca.gov	Organic ID/Batch Number		
<input type="checkbox"/> 75% =		Total Reimbursable Amount \$	
Approved By			

Federal Organic Certification Cost Share Application (ORG-106) Instructions

California Department of Food and Agriculture Organic Registration Number: Enter the 8 digit number assigned by CDFA on your registration certificate. (00-000000)

Are you registered with the California Department of Public Health? If yes, enter the registration number assigned by CDPH on your registration certificate. If not, check NO.

Company Information

Payee Name Box: Enter the name of the company or the name of the individual that the check will be made payable to. **Please note Payee Name must match Payee's Legal Business Name on the STD. 204 Payee Data Record.**

NOTE: On the STD. 204, if your name or sole proprietor business name is entered in the Payee's Legal Business Name box, and your name is in the Sole Proprietor box, then enter your social security number. All others should enter the Federal Employer Identification Number. See STD. 204 instructions for box 3.

Company Name Box: Enter name of your company. If you entered your name as the Payee in the Payee Name box then enter your Company name. If you do not have a company name but use your own name as the business name then enter your name.

Mailing Address Box: Enter the address where you would like your check mailed. Must match STD. 204 Mailing Address box.

Primary County of Operation Box: Enter the county in which you are Registered Organic.

Primary Phone Number Box: Enter the phone number where you can be reached for any questions.

Alternate Phone Number: Enter the alternate number where you can be reached, or enter N/A.

Fax Number: Enter the fax number that we can use to communicate with you, or enter N/A.

E-mail Address Box: Enter the e-mail that you can be reached at for any questions.

Certification Information

Name of Certification Agency: Enter the name of your third party certifier.

Certification Number/Client Code: Enter the certificate number from your certifier's certificate of compliance.

Current date of Certification/Certificate Issued: For renewals: Enter the current issue date on your certificate, not the original date that you obtained certification. For new: Enter the date that you obtained certification.

Application Fee: Enter the fee paid if you are a NEW applicant for certification only, otherwise enter \$0.

Annual Certification/Recertification Fee: Enter the fees paid for your annual certification fee.

Inspection Fee: Enter the costs incurred for your annual inspection.

Total Amount of Fees Paid for Certification: Enter the total of your application fee, annual fee and inspection fee. (See enclosed Acceptable/Unacceptable Organic Cost Share Application Fees for information on what fees can be reimbursed)

Scope of Certification: Check the appropriate box(es) that apply to your scope(s) of certification.

Operation Types for this Certification: Check the appropriate box(es) that apply to your operation(s). (Post Harvest Handling is considered the same as Handling and is acceptable as a scope of work.)

Signature: The application must be signed. The owner or a representative of the company must sign and will be responsible to ensure that the information on the application is true and correct.

Date: Enter the date that the application was completed.

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) _____		
	SOLE PROPRIETOR - 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	ENTER FEDERAL EMPLOYER IDENTIFICATION NUMBER (FEIN): <input type="text"/> - <input type="text"/> <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST <input type="checkbox"/> INDIVIDUAL OR SOLE PROPRIETOR ENTER SOCIAL SECURITY NUMBER: <input type="text"/> - <input type="text"/> - <input type="text"/> <small>(SSN required by authority of California Revenue and Tax Code Section 18646)</small>	CORPORATION: <input type="checkbox"/> MEDICAL (e.g., dentistry, psychotherapy, chiropractic, etc.) <input type="checkbox"/> LEGAL (e.g., attorney services) <input type="checkbox"/> EXEMPT (nonprofit) <input type="checkbox"/> ALL OTHERS	NOTE: Payment will not be processed without an accompanying taxpayer I.D. number.
4	<input type="checkbox"/> California resident - Qualified to do business in California or maintains a permanent place of business in California. <input type="checkbox"/> California nonresident (see reverse side) - Payments to nonresidents for services may be subject to State income tax withholding. <input type="checkbox"/> No services performed in California. <input type="checkbox"/> 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
	SIGNATURE	DATE	TELEPHONE ()
6	Please return completed form to: Department/Office: <u>CA Department of Food and Agriculture, Inspection & Compliance Branch</u> Unit/Section: <u>California State Organic Program, Attn: Sharon Parsons</u> Mailing Address: <u>1220 N Street</u> City/State/Zip: <u>Sacramento, CA 95814</u> Telephone: <u>(916) 900-5202</u> Fax: <u>(916) 900-5347</u> E-mail Address: <u>sparsons@cdfa.ca.gov</u>		

PAYEE DATA RECORD

STD. 204 (Rev. 6-2003) (REVERSE)

1	<p><u>Requirement to Complete Payee Data Record, STD. 204</u></p> <p>A completed Payee Data Record, STD. 204, is required for payments to all non-governmental entities and will be kept on file at each State agency. Since each State agency with which you do business must have a separate STD. 204 on file, it is possible for a payee to receive this form from various State agencies.</p> <p>Payees who do not wish to complete the STD. 204 may elect to not 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 backup withholding and nonresident State income tax withholding. Amounts reported on Information Returns (1099) are in accordance with the Internal Revenue Code and the California Revenue and Taxation Code.</p>
2	<p>Enter the payee's legal business name. Sole proprietorships must also include the owner's full name. An individual must list his/her full name. The mailing address should be the address at which the payee chooses to receive correspondence. Do not enter payment address or lock box information here.</p>
3	<p>Check the box that corresponds to the payee business type. Check only one box. Corporations must check the box that identifies the type of corporation. 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 the California Revenue and Taxation Code Section 18646 to facilitate tax compliance enforcement activities and the preparation of Form 1099 and other information returns as required by the Internal Revenue Code Section 6109(a).</p> <p>The TIN for individuals and sole proprietorships is the Social Security Number (SSN). Only partnerships, estates, trusts, and corporations will enter their Federal Employer Identification Number (FEIN).</p>
4	<p><u>Are you a California resident or nonresident?</u></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Payments to all nonresidents may be subject to withholding. Nonresident payees performing services in California or receiving rent, lease, or royalty payments from property (real or personal) located in California will have 7% of their total payments withheld for State income taxes. However, no withholding is required if total payments to the payee are \$1,500 or less for the calendar year.</p> <p>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</p>
5	<p>Provide the name, title, signature, and telephone number of the individual completing this form. Provide the date the form was completed.</p>
6	<p>This section must be completed by the State agency requesting the STD. 204.</p>
	<p><u>Privacy Statement</u></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>All questions should be referred to the requesting State agency listed on the bottom front of this form.</p>