

PAYROLL PROCEDURES MANUAL

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(Revised 01/23)

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Malia M. Cohen
California State Controller

Date:

Agency/Unit:

Dear: [NAME]

SSN: [XXX-XX-XXXX]

The repayment of an account receivable by an employee to the State of California for an overpayment of wages is normally reflected as a wage decrease on the Form W-2, Wage and Tax Statement issued by the State Controller's Office. However, your Form W-2 does not reflect this information since the total account(s) receivable gross amount you repaid exceeds the reportable wages issued in 2021.

Therefore, we are providing the following information, which represents the account(s) receivable you repaid (partial or in full) during the 2021 tax year:

Account Receivable (s) # «AR» for the «PAYPER» pay period (s) were repaid by you, either partially or in full, during the 2021 tax year.

Total taxable gross amount repaid: \$ «AMOUNT»

NOTE: The taxable gross amount repaid is what is reflected on your Form W-2 as a reduction.

Please contact your local Internal Revenue Service or Franchise Tax Board Office for information on how to reflect this information on your tax returns.

If you have additional questions related to W-2 reporting information, please contact the Statewide Customer Contact Center at (916) 372-7200.

Sincerely,

A handwritten signature in black ink that reads "Monique Perez". The signature is written in a cursive, flowing style.

Monique Perez, Program Manager
Personnel and Payroll Operations Bureau
Statewide Tax Support Program
JEB:MP:LT:STSP:PPOB

Enclosure



Malia M. Cohen
California State Controller

Date:

Agency/Unit:

Dear: [NAME]

SSN: [XXX-XX-XXXX]

The repayment of an account receivable by an employee to the State of California for an overpayment of wages is normally reflected as a wage decrease on the Form W-2, Wage and Tax Statement issued by the State Controller's Office. However, since you had no reportable wages for the 2021 tax year, no Form W-2 will be issued.

Therefore, we are providing the following information that represents the account(s) receivable you repaid during the 2021 tax year:

Account Receivable (s) #«AR» for the «PAYPER» pay period (s) were repaid by you, either partially or in full, during the 2021 tax year.

Total gross amount repaid: \$ «AMOUNT»

NOTE: The taxable gross amount repaid is what is reflected on your Form W-2 as a reduction.

Please contact your local Internal Revenue Service or Franchise Tax Board Office for information on how to reflect this information on your tax returns.

If you have additional questions related to W-2 reporting information, please contact the Statewide Customer Contact Center at (916) 372-7200.

Sincerely,

A handwritten signature in cursive script that reads "Monique Perez".

Monique Perez, Program Manager
Personnel and Payroll Operations Bureau
Statewide Tax Support Program, W-2 Unit

JEB:MP:LT:STSP:PPOB

SAMPLE SAMPLE SAMPLE
STATE OF CALIFORNIA

DIRECT DEPOSIT NUMBER
07-999999

DIRECT DEPOSIT ADVICE

CDSBA REV 8/08

	DOLLARS	CENTS
AMOUNT DEPOSITED *	*2661	24

TO M B HUNT

999 - 999
AGENCY UNIT

NOT
NEGOTIABLE



SAMPLE
STATE CONTROLLER

When changing accounts or financial institutions, notify your personnel office immediately.
Do not close your old account until you have received your first payment in your new account.

STATE OF CALIFORNIA	STATEMENT OF EARNINGS AND DEDUCTIONS	OFFICE OF STATE CONTROLLER
M B HUNT	PAY PERIOD 1001	SOC SEC NO 9999
AGY/UNIT 999-999	ISSUE DATE 10/31/01	DIRECT DEP # 99-999999
TAX YEAR 01		BANK TRANSIT 999999999
TAX STATUS FFD M-02 STATE M-07		

	GROSS PAY	TAXABLE GROSS	DEDUCTIONS	NET PAY
CURRENT *	5480.00	4748.46	1456.07	2661.24
YEAR-TO-DATE	60280.00			

EARNINGS	DETS	HOURS	GROSS	DEDUCTIONS	AMOUNT
REGULAR			5480.00		
				FEDERAL TAX	568.46
				STATE TAX	136.85
				RETIREMENT	248.35
				SOC SEC	331.50
				MEDICARE	77.53
				* F BLUESHLD	87.32
				* PARKING	37.00
				* 457 PLAN	200.00
				* 401K PLAN	150.00
				PT MDCO CU	634.00
				SVGS BOND	100.00
				CHTL CNTRB	5.00
				FED TAX ADJ	150.00
				ST TAX ADJ	50.00
				FS-CSEA	42.75

EMPLOYER CONTRIBUTIONS (interest and adjustments)

RETIREMNT	SOC SEC	HILTH/FLEX
228.30	331.50	346.00
MEDICARE		
77.53		

	9/01	BEGIN BAL	CREDIT	USED	MISC	10/01 BEGIN
ANNUAL		607.00	20.00	0.00	0.00	627.00
SICK LV		450.00	0.00	0.00	0.00	450.00
PH		1.00	0.00	0.00	0.00	1.00 UNITS
HOL CR		8.00	0.00	0.00	0.00	8.00

*THE STATE CONTROLLER REMINDS EVERYONE THAT "YOUTH AND AIDS IN THE 21ST CENTURY" IS THE THEME FOR WORLD AIDS DAY, WHICH WILL BE OBSERVED ON 12/1/01. VISIT THE OFFICE OF AIDS WEBSITE AT [HTTP://WWW.DHS.CA.GOV/AIDS/](http://www.dhs.ca.gov/aids/) FOR INFO.

TO: STATECONTROLLER'S OFFICE

FROM: AGENCY/CAMPUS

TAX AND WAGE REPORTING FOR INDEPENDENT CONTRACTORS RECLASSIFIED AS EMPLOYEES

NAME/SSN	POSITION NUMBER	TIME PAID	GROSS	FIT	SS/MED	(EE/ER)
PT CRUISER 000-00-0000	051-000-0000-000	1/1/01-12/31/01	78,152.98	21,882.83	5,978.70	5,978.70
SD WORKER 000-00-0000	051-000-0000-000	6/1/00-12/21/00	35,014.25	9,803.99	2,678.59	2,678.59
SD WORKER 000-00-0000	051-000-0000-000	1/1/01-06/30/01	36,123.01	10,114.44	2,763.41	2,763.41
TOTAL TAXES				41,801.26	11,420.70	11,420.70
TOTAL AGENCY REMITTANCE					64,642.66	

TO: EMPLOYMENT DEVELOPMENT DEPARTMENT
EMPLOYMENT STATUS UNIT

FROM: AGENCY/CAMPUS

WAGE REPORTING FOR UNEMPLOYMENT INSURANCE PURPOSES

2001	1 st QUARTER	2 nd QUARTER	3 rd QUARTER	4 th QUARTER
PT CRUISER 000-00-0000	19,538.24	19,538.24	19,538.25	19,538.25
SD WORKER 000-00-0000	18,061.50	18,061.51		

cc: TSS, SCO

**ATTACHMENT I-8
(Revised 01/08)**

TO: Recipient of Warrants for
Deceased Employee

FROM: Agency/Campus Name

The attached warrant(s) represent payments (e.g. remaining salary amounts, lump sum vacation, etc.) due the above named employee. While this office cannot provide tax advice, these payments may be taxable, but are not subject to Federal or State Income Tax withholding. If taxes were withheld, a refund will be issued. Payments issued in the year of death are subject to applicable Social Security and/or Medicare and State Disability Insurance withholding. Payments issued in years following death are not subject to Social Security and/or Medicare or State Disability Insurance withholding. If Social Security/Medicare or State Disability Insurance were withheld, a refund will be issued.

You will receive a Form 1099-MISC stating these payments were released to you, in your Social Security Number (or Taxpayer Identification Number).

PLEASE DIRECT ANY TAX QUESTIONS TO YOUR TAX CONSULTANT.

**ATTACHMENT I-9
(Revised 03/02)**

DEPARTMENT OF THE TREASURY
INTERNAL REVENUE SERVICE
HOLTSVILLE NY 00501

DATE OF THIS NOTICE: 09
NUMBER OF THIS NOTICE:
EMPLOYER IDENTIFICATION
NUMBER 22-6670158
FORM SS-4
1916726678 B

FOR ASSISTANCE CALL US AT: 1-800-829-1040

OR WRITE TO THE ADDRESS SHOWN AT THE TOP LEFT.

IF YOU WRITE, ATTACH THE
STUB OF THIS NOTICE.

WE ASSIGNED YOU AN EMPLOYER IDENTIFICATION NUMBER (EIN)

Thank you for your Form SS-4, Application for Employer Identification Number (EIN). We assigned you EIN 22-6670158. This EIN will identify your business account, tax returns, and documents, even if you have no employees. Please keep this notice in your permanent records.

Use your complete name and EIN shown above on all federal tax forms, payments, and related correspondence. If you use any variation in your name or EIN, it may cause a delay in processing, incorrect information in your account, or cause you to be assigned more than one EIN.

Based on the information shown on your Form SS-4, you must file the following form(s) by the date we show.

Form 1041 04/15/96

If the due date has passed please complete the form and send it to us by 10-13-95. If we don't receive the form by that date additional penalties and interest will be charged. If you weren't in business or didn't hire employees for the tax period shown, please file the form showing that you have no liability.

If you need help in determining what your tax year is, you can get Publication 538, Accounting Periods and Methods, at your local IRS office.

If you have any questions about the forms shown or the date they are due, you may call us at 1-800-829-1040 or write to us at the address shown above.

Thank you for your cooperation.

ATTACHMENT I-10
(Revised 03/2022)

SUBMIT COMPLETED FORM TO:
ConnectHR
Document Type: W2-UNIT-PPSD-21



STATE CONTROLLER'S OFFICE
DECEASED EMPLOYEE DATA FORM

A. Deceased Information

Deceased's Name (first, middle initial, last)	Social Security Number
Date of Death (MM/DD/YYYY)	Agency Name/Unit

B. Beneficiary/Designee Information Only

Social Security Number or Tax Payer Identification (must be completed)		
Name (first, middle initial, last)		
Street Address		
City	State	Zip Code

C. Warrant Information

Issue Date	Warrant Taxable Gross Amount	Warrant Number
Total Taxable Gross Amount:		State Code:

D. Authorized Signature

I certify that I am duly authorized by the herein named state agency to make this report and certification; the information stated herein is correct, complete and in accordance with all laws and regulations.

Agency/Campus Name	Email
Reporting Officer Signature	Date Signed
Specialist Name	Telephone Number

(Filing instructions on reverse side)

**State Controller's Office
Deceased Employee Information
W-2 Unit**

INSTRUCTIONS

Please complete every field of the PPSD-21 form.

Ensure that all information is accurate.

Do not enter ditto marks to indicate duplicate line information.

A. Deceased Information

Enter the deceased employee's first, middle initial followed by surname.

Enter the deceased employee's date of death.

Enter the deceased employee's Social Security Number.

Enter the deceased employee's agency and unit numbers.

B. Beneficiary/Designee Information

Enter the beneficiary/designee's Social Security Number. If the beneficiary/designee is an estate rather than an individual, report (from Federal Form W-9, Request for Taxpayer Identification Number (TIN) and Certification or Form SS-4, Application for Employer Identification Number) the Taxpayer Identification Number.

Enter the beneficiary/designee's first, middle initial followed by surname from the STD 243 form, Designation of Person Authorized to receive warrants, or directly from the beneficiary/designee.

Enter the beneficiary/designee's street address, city, state, and zip code.

C. Warrant Information

Enter the issue date(s) of the warrant. DO NOT include payments issued before the date of death (S95 transaction), but released to the beneficiary/designee. All reported payments must be issued after the date of death. DO NOT include tax (Federal, State, Social Security, Medicare or State Disability Insurance) fund warrants issued by the State Controller's Office.

Enter the warrant taxable gross amount for each payment released to the beneficiary/designee. Taxable gross is identified as "Gross Amount" found next to the Federal/State Income Tax amounts. (To manually compute the taxable gross amount, subtract retirement, deferred compensation, flex benefits and/or code 035 deductions from the gross amount of the payment. All amounts which affect taxable gross have an asterisk (*) after them.)

Enter the warrant number for each payment.

Enter the total taxable gross amount of all warrants released to the beneficiary/designee.

Enter the State Code: CA, NY, IL, or leave blank.

D. Authorized Signature

Enter the agency/campus name and email address.

Signature of the reporting officer is required.

Enter the current date.

Enter the specialist name and telephone number.

For questions please email: PPSDW2MiscDed@sco.ca.gov

FORM W-2 REPORTING

CHART I

EFFECTIVE 2001 & FUTURE

(Note: 2000 & prior refer to Charts III & IV)

Reimbursements are included in the following Form W-2 boxes:

Box	Title	Reported
1	Wages, tips other compensation	YES
2	Federal income tax withheld	YES
3	Social Security wages	YES
4	Social Security tax withheld	YES
5	Medicare Wages and tips	YES
6	Medicare tax withheld	YES
16	State wages, tips, etc.	YES
17	State income tax	YES

Special Reporting:

Box	Title	Reported
14	Benefits included in box 1	YES

FORM W-2 REPORTING

CHART II

EFFECTIVE 2001 & FUTURE

(Note: 2000 & prior refer to Charts III & IV)

Reimbursements are included in the following Form W-2 boxes:

Box	Title	Reported
1	Wages, tips other compensation	YES
2	Federal income tax withheld	YES
3	Social Security wages	YES
4	Social Security tax withheld	YES
5	Medicare Wages and tips	YES
6	Medicare tax withheld	YES
16	State wages, tips, etc. (California/New York Only)	NO
17	State income tax (California/New York Only)	NO

Special Reporting:

Box	Title	Reported
14	Benefits included in box 1	YES

FORM W-2 REPORTING

CHART III

Refers to 2000 & prior years

Reimbursements are included in the following Form W-2 boxes:

Box	Title	Reported
1	Wages, tips other compensation	YES
2	Federal income tax withheld	YES
3	Social Security wages	YES
4	Social Security tax withheld	YES
5	Medicare Wages and tips	YES
6	Medicare tax withheld	YES
17	State wages, tips, etc.	YES
18	State income tax	YES

Special Reporting:

Box	Title	Reported
12	Benefits included in box 1	YES

FORM W-2 REPORTING

CHART IV

Refers to 2000 & prior years

Reimbursements are included in the following Form W-2 boxes:

Box	Title	Reported
1	Wages, tips other compensation	YES
2	Federal income tax withheld	YES
3	Social Security wages	YES
4	Social Security tax withheld	YES
5	Medicare Wages and tips	YES
6	Medicare tax withheld	YES
17	State wages, tips, etc.	NO
18	State income tax	NO

Special Reporting:

Box	Title	Reported
12	Benefits included in box 1	YES

Fringe Benefit Processing and Special Accounting Period

Received Benefit	Submitted Form 676V	Withheld FIT/SIT	Reported on Form W-2	Comments
December 1998	January 1 – 10, 1999	Yes	Yes	Issue Date must be 1/1/99
January	February 1 – 10	Yes	Yes	
February	March 1 – 10	Yes	Yes	
March	April 1 – 10	Yes	Yes	
April	May 1 – 10	Yes	Yes	
May	June 1 – 10	Yes	Yes	
June	July 1 – 10	Yes	Yes	
July	August 1 – 10	Yes	Yes	
August	September 1 – 10	Yes	Yes	
September	October 1 – 10	Yes	Yes	
October	November 1 – 10	Yes	Yes	
November	December 1 – 10	No	Yes	Only SS/MED Withheld
November	December 11 – 22	No	Yes	A/R Established for SS/MED
November	January 1, 2000 or later	No	No	Corrected W-2 Generated