



# VENDOR QUESTIONNAIRE

## 1. GENERAL INFORMATION (Please print or type)

Name of Business: \_\_\_\_\_  
Type of Business: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
Post Office Address: \_\_\_\_\_  
City, State, and Zip: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_  
Key Contact for Offers \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Number of Employees: \_\_\_\_\_ Annual Revenue \_\_\_\_\_

## 2. LICENSE INFORMATION (Complete all that apply):

- Federal Tax Identification Number: \_\_\_\_\_  
 California Tax Identification Number: \_\_\_\_\_
- Contractor / Professional License Number: \_\_\_\_\_  
Contractor /Professional License Expiration Date: \_\_\_\_\_  
Contractor /Professional License Type: \_\_\_\_\_
- Business License (City & No). \_\_\_\_\_ Exp. Date: \_\_\_\_\_
- Has a business license application been obtained and approved by the Business License Tax Division of the County of Contra Costa to do business in the unincorporated area of the County?  YES  NO  N/A
- If using a fictitious business name which county is your fictitious business name registered at: (Indicate County) \_\_\_\_\_ State \_\_\_\_\_
- Date fictitious business name registered: \_\_\_\_\_  
Expiration Date: \_\_\_\_\_

## 3. BUSINESS CATEGORY (check all that are applicable)

- Minority-Owned:** Fifty-one percent of business or stock is owned, and management of daily business operations is controlled by one or more members of the following groups: Black Americans, Hispanic Americans, Native Americans, Asian-Pacific American, or Asian Indian Americans.  
Is your company certified as minority owned?  Yes  No  
Name of Certifying Agency: \_\_\_\_\_
- Women-Owned:** A business that is at least 51 percent owned, controlled, and operated by a woman or women.

**Hub zone Small Business:** A historically underutilized business zone which is in an area located with one or more qualified census tracts, qualified non-metropolitan counties, or lands within the external boundaries of an Indian Reservation.

**Small Business** (not in Hub zone) “means a business concern, including its affiliates, that is independently owned and operated, not dominant in the field of operation in which it is bidding, and qualified as a small business” under federal regulations 13 CFR 121.

**4. BUSINESS TYPE** (check one)

Corporation: Date founded: \_\_\_\_\_ State of Incorporation: \_\_\_\_\_  
Name and Titles of Officers or Principals: \_\_\_\_\_

Corporate Business Name: \_\_\_\_\_  
Under what other or former names has your corporation operated? \_\_\_\_\_

Is your firm owned or controlled by another organization or company?  Yes  No  
If yes, provide name of organization or company. \_\_\_\_\_

List any other organizations or subsidiaries owned / controlled by this corporation or its officers.

- Government Agency (Local or State)  
 Not for Profit Organization (501) (c) (3)  
 Sole Proprietor: Name of Owner(s): \_\_\_\_\_  
 Partnership: Name of Partners: \_\_\_\_\_

**5. BUSINESS CLASSIFICATION** (check all that apply)

- Financial Institution, Insurance Carrier or Broker, Real Estate  
 Services, e.g., architect, engineering, accounting, misc. repairs, automotive repairs, legal services, consultants, other professional or personal business services.  
 Retailer or Wholesaler of durable or non-durable goods  
 Construction, e.g., building general contractors, special trade contractors, etc...  
 Other – Specify \_\_\_\_\_

**6. REFERENCES** (at least 3 references)

**Reference 1**

Name of Reference	
Name and Title of Contact	
Address of Contact	
Telephone Number	

**Reference 2**

Name of Reference	
Name and Title of Contact	
Address of Contact	
Telephone Number	

**Reference 3**

Name of Reference	
Name and Title of Contact	
Address of Contact	
Telephone Number	

**7. INSURANCE COVERAGE (Check all that apply):**

General Liability to include either  Personal Injury and/or  Property

Name of Carrier: \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_  
\_\_\_\_\_

Automobile / Vehicle:

Name of Carrier: \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_  
\_\_\_\_\_

Workers Compensation:

Name of Carrier: \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_  
\_\_\_\_\_

Specify any other insurance type: \_\_\_\_\_

Name of Carrier: \_\_\_\_\_  
Address of Carrier: \_\_\_\_\_  
\_\_\_\_\_

**8. FREIGHT TERMS (Check one)**

FOB SHIPPING POINT (ORIGIN)  FOB DESTINATION

**9. Data Universal Numbering System (DUNS) number issued by Dun & Bradstreet (if applicable or available):**

\_\_\_\_\_

**10. STANDARD PAYMENT TERMS (Check and complete as appropriate)**

Net 30  \_\_\_\_\_ % Net 10  Other-Specify: \_\_\_\_\_

**11. COMMENTS (provide any other information that you believe the HACCC should know about your company or corporation, e.g., is you company bonded, staff professional certifications, etc...):**

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*This is to certify that the information provided is true and accurate as of the date set forth opposite my signature and that any intentional or negligent misrepresentation of the information contained in this document may result in civil liability, including monetary damages, to any person who may suffer any loss due to the reliance upon the document, and/or in criminal penalties including but not limited to fine or imprisonment or both under the provisions of Title 18 United States Code Sections 1001 et seq. I understand and acknowledge that any action taken by the HACCC is in strict reliance on the information provided. My signature grants the HACCC or its designee the authority to confirm or verify the information I have disclosed in this questionnaire.*

Information provided by:

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Print Name and Title

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Signature

Date: \_\_\_\_\_

HACCC Verification by:

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Print Name, Title

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Signature

Date: \_\_\_\_\_