

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name
Department of Health Care Services
Division, Department, or Region (if applicable)
Health Care Delivery Systems
Street Address
1501 Capitol Ave, Sacramento, CA 95899
Area Code/Phone Number
Email
Agency Contact (name and title)
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual
Other Center of Health Care Strategies, Inc.
200 American Metro Blvd, Suite 119 Hamilton NJ 08619
Address City State Zip Code
501(c)(4)
If "Other" is marked, describe the entity's business activity (if business) or its nature and interests.
If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Chicago, IL June 6-9, 2015
Location of Travel Dates (month, day, year)
Southwest Rail Air Bus Auto Other Double Tree Hilton
Transportation Provider Check Applicable Boxes Name of Lodging Facility
\$ 707.72 \$ Meal Expenses \$ 556.01 \$ Other Expenses \$ 1,263.73
Lodging Expenses Transportation Expenses Total Expenses
3.1 (b) Payment(s) not related to travel:
Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
Travel to participate in the National Association of Medicaid Directors Spring Conference.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Katch Hannah Assistant Deputy Director Health Care Delivery System
Last Name First Name Position/Title Department/Division

4. Verification
I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.
Signature Karen Johnson Chief Deputy Director 7/29/15
Print Name Title (month, day, year)

Comment:
(Use this space or an attachment for any additional information)

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