

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

Last Name

First Name

Other

Center of Health Care Strategies, Inc.

Name

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:

Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment

Chicago, IL

Location of Travel

June 6-9, 2015

Dates (month, day, year)

Delta Airlines

Transportation Provider

Rail

Air

Bus

Auto

Other

Check Applicable Boxes

Double Tree Hilton

Name of Lodging Facility

\$ 904.44

Lodging Expenses

\$

Meal Expenses

\$ 656.20

Transportation Expenses

\$

Other Expenses

\$ 1,560.64

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)

Brooks

Last Name

Sarah

First Name

Deputy Director

Position/Title

Health Care Delivery System

Department/Division

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

Print Name

Chief Deputy Director

Title

7/29/15 (month, day, year)

Comment:

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