Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration Division, Human Resources Branch

Street Address

P.O. Box 997411, MS 1300

Area Code/Phone Number: (916) 552-8270

Email: ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: 06/17/16 (month, day, year)

2. Donor Name and Address

☐ Individual _____ Last Name _____ First Name

☑ Other California HealthCare Foundation (Name)

1415 L Street #820 (Address) Sacramento (City) CA (State) 95814 (Zip Code)

Promotes better care for all Californians by improving the health care system.

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

Los Angeles, CA (Location of Travel) 05/11/2016-05/13/2016 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Fairmont Newport Beach (Name of Lodging Facility)

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$340.70	$0.00	$244.55	$0.00	$585.25

3.1 (b) Payment(s) not related to travel: 359.00 (Dates (month, day, year)) $ 359.00 (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Reimbursement for travel to attend and participate in the Coalition for Compassionate Care of California's 8th Annual Summit.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)

Last Name	First Name	Position/Title	Department/Division
Dodson	Anastasia	Associate Director	Director's Office

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature	Print Name	Title	(month, day, year)
ORIGINAL ON FILE	Karen Johnson	Chief Deputy Director	07/21/16

Comment:

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

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