

Gift to Agency Report

A Public Document

GIFT TO AGENCY REPORT

<b>1. Agency Name</b> Department of Health Care Services		Date Stamp	<b>California Form 801</b> For Official Use Only
Division, Department, or Region (if applicable) Director's Office			
Street Address P.O. Box 997413 MS 0000 Sacramento, CA 95814			
Area Code/Phone Number 916-440-7400	E-mail renee.ernst@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ <small>(month, day, year)</small>	
Agency Contact (name and title) Renee Ernst			

2. Donor Name and Address

Individual \_\_\_\_\_  Other Center for Health Care Strategies

Last Name First Name Name

200 American Metro Blvd., Suite 119 Hamilton NJ 08619

Address City State Zip Code

Non-profit, Center for Health Care Strategies (CHCS) is dedicated to improving health care access and quality.  
 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) solicited or received by the donor for this gift:

_____	\$ _____	_____	\$ _____
<small>Name</small>	<small>Amount</small>	<small>Name</small>	<small>Amount</small>

3. Payment Information

Date and Amount of Payment (other than travel) \_\_\_\_\_ \$ \_\_\_\_\_  
(month, day, year) (Round to whole dollars)

Travel Payment Information (Round to whole dollars) Location of Travel Alexandria, Virginia

<u>02/10-13/2013</u>	\$ <u>864.12</u>	\$ <u>211.72</u>	\$ <u>15.59</u>	\$ <u>0</u>	\$ <u>1091.43</u>
<small>Date(s) of Travel</small>	<small>Transportation Expenses</small>	<small>Lodging Expenses</small>	<small>Meal Expenses</small>	<small>Other Expenses</small>	<small>Total Expenses</small>

**Provide a specific description of the nature and use of the payment for official agency business:**

Attend a summit on "hot spotting" - managing the most costly, high-need patients. The summit is cosponsored by the National Governor's Association. The information gained will be applied to the State's Coordinated Care Initiative and Managed Care Delivery System.

Identify the officials for whom the payment was used:

<u>Kohatsu</u>	<u>Neal</u>	<u>Medical Director</u>	<u>Director's Office</u>
<small>Last Name</small>	<small>First Name</small>	<small>Title</small>	<small>Department/Division</small>
_____	_____	_____	_____
<small>Last Name</small>	<small>First Name</small>	<small>Title</small>	<small>Department/Division</small>

4. Verification

I have determined that it is in the interests of the agency to accept this gift and use it for the official agency business described above.

	<u>Karen Johnson</u>	<u>Chief Deputy Director</u>	<u>03/14/2013</u>
<small>Signature of Agency Head or Designee</small>	<small>Print Name</small>	<small>Title</small>	<small>(month, day, year)</small>

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