Gift to Agency Report — A Public Document

GIFT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

California Department of Health Care Services

Division, Department, or Region *(if applicable)*

Street Address

1501 Capitol Avenue, Sacramento, CA 95814

Area Code/Phone Number: (916) 440-7418

E-mail: brian.hansen@dhcs.ca.gov

Agency Contact *(name and title)*

Brian Hansen - Special Assistant to the Director

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

Date of Original Filing: 12-22-09 *(month, day, year)*

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☒ Other American Medicaid Pharm. Admin. Assoc. (Name)

3260 Legacy Drive (Address) Anchorage (City) AK (State) 99516 (Zip Code)

Non-profit promoting information sharing for Medicaid Pharmacy Administrators.

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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** Chicago, Illinois

Date(s) of Travel	Transportation Expenses	Lodging Expenses	Meal Expenses	Other Expenses	Total Expenses
10-11 to 10-14, 200	$654.33	$379.40	$180.00	$0	$1213.73

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

Travel to a conference to discuss Medicaid pharmacy policy business with representatives from other state Medicaid programs.

Identify the officials for whom the payment was used:

Last Name	First Name	Title	Department/Division
Gorospe	Kevin	Chief, Pharm. Pol. Bran.	Pharmacy Benefits Div.

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.

Brian L. Hansen (Signature of Agency Head or Designee) Brian Hansen (Print Name) Special Assistant to the Director (Title) 12/22/09 *(month, day, year)*

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