

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)
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
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
70 Washington Street Oakland CA 94607
Address City State Zip Code
CA Assn of Public Hospitals & Health Sys
Name
CAPH has served as the health policy and advocacy voice for our members at both the state and federal levels
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
San Francisco, CA
Location of Travel
August 4, 2016
Dates (month, day, year)
La Schick Limousine
Transportation Provider
Rail Air Bus Auto Other
Check Applicable Boxes
Name of Lodging Facility
\$ 88.00 \$ 968.00
Lodging Expenses Meal Expenses Transportation Expenses Other 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.
Shuttle transportation services at \$88.00 per person for 11 DHCS employees to visit the Zuckerberg San Francisco General Hospital and Trauma Center.
3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
See attached list
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.
ORIGINAL ON FILE Karen Johnson Chief Deputy Director 10/17/16
Signature Print Name Title (month, day, year)
Comment:
(Use this space or an attachment for any additional information)
FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

San Francisco General Hospital and Trauma Center Site Visit

Date of Travel: August 4, 2016

ATTACHMENT TO FORM 801: DHCS-FPPC-801-10-31-16-01

LAST NAME	FIRST NAME	POSITION/TITLE	DEPARTMENT
Dahl	Michael	Assoc Budget Analyst	Health Care Services
Fotopoulos	Panayoitis	Staff Services Analyst	Health Care Services
Geisen	Katie	Assoc Gov't Program Analyst	Health Care Services
Giannini	Gina	Staff Services Analyst	Health Care Services
Lai	Betty	Staff Services Manager III	Health Care Services
On	Samantha	Staff Services Analyst	Health Care Services
Saechao	David		Health Care Services
Schoch	Heather	Assoc Gov't Program Analyst	Health Care Services
Widjaja	Soma	Staff Services Manager I	Health Care Services
Witz	Ryan	CEA	Health Care Services
Yosgott	Matthew	Staff Services Manager I	Health Care Services