

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
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 Name

Address City State Zip Code

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

Location of Travel Dates (month, day, year)
Transportation Provider Rail Air Bus Auto Other
Name of Lodging Facility
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.

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

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 Print Name Title (month, day, year)

Comment:

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Street Address P.O. Box 997411, MS 1300			
Area Code/Phone Number (916) 552-8270	Email conflictinterest@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section)	
Agency Contact (name and title) Conflict of Interest Filing Officer		Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

Individual \_\_\_\_\_ Last Name First Name  Other \_\_\_\_\_ Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

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

3.1 (a) Travel Payment

\_\_\_\_\_ Location of Travel \_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_

\_\_\_\_\_  Rail  Air  Bus  Auto  Other \_\_\_\_\_  
 Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

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Agency Contact (name and title)		Date of Original Filing: _____ (month, day, year)	

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Individual \_\_\_\_\_ Last Name First Name  Other \_\_\_\_\_ Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

**3.1 (a) Travel Payment**

\_\_\_\_\_ Location of Travel \_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_

\_\_\_\_\_  Rail  Air  Bus  Auto  Other \_\_\_\_\_ Name of Lodging Facility \_\_\_\_\_

\_\_\_\_\_ Check Applicable Boxes \_\_\_\_\_

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

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

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P.O. Box 997411, MS 1300, Sacramento, CA 95899-7411			
Area Code/Phone Number	Email	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
(916) 552-8270	ConflictofInterest@dhcs.ca.gov		
Agency Contact (name and title)			
Conflict of Interest Filing Officer			

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Individual \_\_\_\_\_  Other \_\_\_\_\_

Last Name                      First Name                      Name

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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Name                      Amount                      Name                      Amount

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

3.1 (a) Travel Payment

\_\_\_\_\_ Location of Travel \_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_

\_\_\_\_\_  Rail  Air  Bus  Auto  Other \_\_\_\_\_

Transportation Provider      Check Applicable Boxes      Name of Lodging Facility

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_

Lodging Expenses      Meal Expenses      Transportation Expenses      Other Expenses      Total Expenses

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\_\_\_\_\_ \$ \_\_\_\_\_

Dates (month, day, year)      Total Expenses

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_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
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