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Agency Name			Date Stamp	California o c
Health and Human Service	es			Form Of
Division, Department, or Reg	jion (ifi applicable)			For Official Use Only
Health Care Services				
Street Address				
1501 Capitol Avenue, Suite	e 6001 MS 0000, Sacramento, C	CA 95814		
Area Code/Phone Number	E-mail		☐ Amendment (evo)	ain in comment section)
916-440-7400	renee.ernst@dhcs.ca.gov			ant an commont coolony
Agency Contact (name and title	9)		Date of Original Filing	j:(month, day, year)
Renee Ernst, Executive As	ssistant			(,, , , , , , , , , , , , , ,
<b>Donor Name and Addre</b>	ess			
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Last Name	First Name			Name
1438 Webster Street, Suite	e 400 Oakland City		CA State	94612 Zip Code
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	deas and innovations that improving business activity (if business) or its nature are		ase efficiency and lo	wer costs of healthcar
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If applicable, identify the name	of each source and the amount(s) s	solicited or receive	ed by the donor for this	s gift:
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