

**Payment to Agency Report** **A Public Document**

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
Department of Health Care Services			
Division, Department, or Region (if applicable) Health Care Delivery Systems			
Street Address 1501 Capitol Ave, Sacramento, CA 95899			
Area Code/Phone Number	Email	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title)			

**2. Donor Name and Address**

Individual  Other Center of Health Care Strategies, Inc.

Last Name	First Name	Name
200 American Metro Blvd, Suite 119	Hamilton	
Address	City	State Zip Code
501(c)(4)		NJ 08619

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** Chicago, IL June 6-9, 2015

Location of Travel Dates (month, day, year)

Delta Airlines  Rail  Air  Bus  Auto  Other Double Tree Hilton

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$904.44	\$	\$656.20	\$	\$1,560.64
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

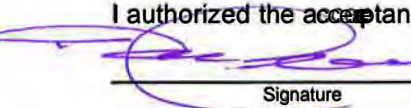
**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**  
 Travel to participate in the National Association of Medicaid Directors Spring Conference.

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

<u>Brooks</u>	<u>Sarah</u>	<u>Deputy Director</u>	<u>Health Care Delivery System</u>
Last Name	First Name	Position/Title	Department/Division
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.

	<u>Karen Johnson</u>	<u>Chief Deputy Director</u>	<u>07/29/15</u>
Signature	Print Name	Title	(month, day, year)

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

