Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

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

Agency Contact (name and title)

Conflict of Interest Filing Officer

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

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

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

☑ Other California Primary Care Association (CPCA) (Name)

1231 I Street, Suite 400 (Address) Sacramento (City) CA (State) 95814 (Zip Code)

CPCA is a statewide leader representing the interests of CA community clinics and health centers and their patients

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

Long Beach, CA (Location of Travel)

October 27-28, 2016 (Dates (month, day, year))

Delta Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Westin Hotel (Name of Lodging Facility)

$224.63 (Lodging Expenses) $_____ (Meal Expenses) $150.00 (Transportation Expenses) $_____ (Other Expenses) $374.63 (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.

To represent the State of California and to participate as a speaker on the new managed care regulations and potential changes to California's policy.

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

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

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

ORIGINAL ON FILE (Signature) Jennifer Kent (Print Name) Director (Title) _____ (month, day, year)

Comment:

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

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