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)

Health Care Delivery Systems

Street Address

1501 Capitol Ave, Sacramento, CA 95899

Area Code/Phone Number: (916) 552-8270

Email: conflictofinterest@dhcs.ca.gov

Agency Contact (name and title)

DHCS 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 Center of Health Care Strategies, Inc. (Name)

200 American Metro Blvd, Suite 119 (Address) Hamilton (City) NJ (State) 08619 (Zip Code)

501(c)(3)

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

Washington, D.C. (Location of Travel) June 30-July 2, 2015 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Hotel Palomar (Name of Lodging Facility)

$476.52 (Lodging Expenses) $34.99 (Meal Expenses) $1,097.01 (Transportation Expenses) $_____ (Other Expenses) $1,608.52 (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 Housing Health Care for People who are Chronically Homeless meeting.

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

Last Name	First Name	Position/Title	Department/Division
Katch	Hannah	Assistant Deputy Director	Health Care Delivery Systen

4. Verification

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

Signature	Print Name	Title	(month, day, year)
Original on File	Karen Johnson	Chief Deputy Director	10/20/2015

Comment:

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