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	**Email**
(916) 552-8270	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 Health Care Foundation
Name

Address	City	State	Zip Code
1438 Webster Street, #400	Oakland	CA	94612

The CHCF promotes better care for all Californians by improving the health care system.

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 North Hollywood, CA
Location of Travel

1/6/17
Dates (month, day, year)

Southwest Airlines
Transportation Provider

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

Name of Lodging Facility

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$	$	$ 137.68	$	$ 137.68

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.

This trip is related to SB 1004/palliative care policy development and implementation efforts.

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

Last Name	First Name	Position/Title	Department/Division
Logan	Julia	Public Hlth Medical Officer	

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	Erika Sperbeck	Chief Deputy Director	

Comment:

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

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