

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual Other California HealthCare Foundation
1438 Webster Street, Suite 400 San Francisco CA 94612
Address City State Zip Code
Non-profit CHCF support ideas and innovations that improve quality, increase efficiency and lower costs of health care
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:

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment
Newport Beach, CA
May 11-13, 2016
Location of Travel Dates (month, day, year)
Southwest Fairmont Newport Beach
Transportation Provider Name of Lodging Facility
Rail Air Bus Auto Other
Check Applicable Boxes
\$361.14 \$23.00 \$309.43 \$364.00 \$1,057.57
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.
Provide expertise insight, tools, and collaboration for DHCS's implementation of the statewide Palliative Care program.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Younger Sabrina Hlth Prog Spec I Mgd Care Quality/Monitor
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.
ORIGINAL ON FILE Karen Johnson Chief Deputy Director 07/21/16
Signature Print Name Title (month, day, year)

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