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 Academy Health (Name)

1666 K St. NW, Suite 1100 (Address) Washington (City) DC (State) 20006 (Zip Code)

Works to improve health and the performance of the health system by supporting the production and use of evidence to in

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, DC (Location of Travel)

April 27-29, 2016 (Dates (month, day, year))

Southwest (Transportation Provider)

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

_____ (Name of Lodging Facility)

$_____ (Lodging Expenses) $80.00 (Meal Expenses) $294.72 (Transportation Expenses) $10.00 (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.

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

Last Name	First Name	Position/Title	Department/Division
Kohatsu	Neal	Medical Director	Ofc of the Medical Director

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	07/21/16

Comment:

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

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