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: 07/18/16 (month, day, year)

2. Donor Name and Address

☐ Individual — Last Name — First Name

☑ Other — California HealthCare Foundation (Name)

1438 Webster Street, Suite 400 (Address) • San Francisco (City) CA (State) 94612 (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:

Name — $ Amount — Name — $ Amount

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

3.1 (a) Travel Payment

Newport Beach, CA (Location of Travel) — May 11-13, 2016 (Dates (month, day, year))

Southwest Airlines (Transportation Provider) — ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) — Fairmont Newport Beach (Name of Lodging Facility)

$200.57	$38.76	$450.98	$742.16	$797.47
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: 5/12/16 (Dates (month, day, year)) — $ 635.00 (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

conference fee $635,
lodging included $20 parking
Other included car rental ($83.72) and transport to/from Sac airport: ($23.44)

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

Last Name	First Name	Position/Title	Department/Division
Abramson	Jill	PHMOIII(s)	DHCS/SCD

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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