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 California Health Care Foundation (CHCF) (Name)

1438 Webster Street (Address) Oakland (City) CA (State) 94612 (Zip Code)

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

Washington, DC (Location of Travel)

05/22/16-05/23/16 (Dates (month, day, year))

American Airlines (Transportation Provider)

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

Courtyard Marriott Washington (Name of Lodging Facility)

$258.77 (Lodging Expenses) $22.81 (Meal Expenses) $590.12 (Transportation Expenses) $5.00 (Other Expenses) $876.70 (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.

To assist DHCS in the implementation of a palliative care policy for Medi-Cal beneficiaries per Senate Bill 1004.

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 Health Medical Offic	DHCS / OMD

4. Verification

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

ORIGINAL ON FILE (Signature) Karen Johnson (Print Name) Chief Deputy Director (Title) _____ (month, day, year)

Comment:

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

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