

Behested Payment Report

A Public Document

Behested Payment Report

1. Elected Officer or CPUC Member (Last name, First name)
Tibbetts, Jack
 Agency Name
City of Santa Rosa
 Agency Street Address
100 Santa Rosa Ave, Santa Rosa, CA
 Designated Contact Person (Name and title, if different)

Date Stamp
FILE
FEB 24 2017
 CITY OF SANTA ROSA
 CITY CLERK'S OFFICE

California Form **803**
 For Official Use Only

Amendment (See Part 5)
 Date of Original Filing: _____
 (month, day, year)

Area Code/Phone Number
707-495-7438
 E-mail (Optional)
hitibbetts@srcity.org

2. Payor Information (For additional payors, include an attachment with the names and addresses.)
Julio R. Gallo Foundation
 Name
PO Box 1130 Modesto CA 95353
 Address City State Zip Code

3. Payee Information (For additional payees, include an attachment with the names and addresses.)
Society of Saint Vincent de Paul
 Name
5671 Redwood Drive
 Address City State Zip Code

4. Payment Information (Complete all information.)
 Date of Payment: 1-26-17 Amount of Payment: (In-Kind FMV) \$ 5,000
 (month, day, year) (Round to whole dollars.)
 Payment Type: Monetary Donation or In-Kind Goods or Services (Provide description below.)
 Brief Description of In-Kind Payment: Event S. HST

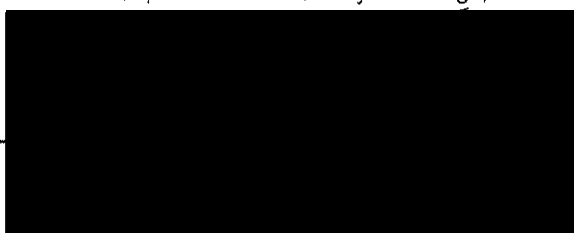
Purpose: (Check one and provide description below.) Legislative Governmental Charitable
 Describe the legislative, governmental, charitable purpose, or event: Event sponsorship of the SVDP's Main Course event that supports the Dining Room.

5. Amendment Description and/or Comments

6. Verification

I certify, under penalty of perjury under the laws of the State of California, that to the best of my knowledge, the information contained herein is true and complete.

Executed on 2-23-17 By _____
 DATE



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Behested Payment Report

1. Elected Officer or CPUC Member (Last name, First name) <u>Tibbets, Jack</u>		Date Stamp FILED FEB 24 2017	California Form 803 For Official Use Only
Agency Name <u>City of Santa Rosa</u>		CITY OF SANTA ROSA CITY CLERK'S OFFICE	
Agency Street Address <u>100 Santa Rosa Ave Santa Rosa CA</u>			Date of Original Filing: _____ (month, day, year)
Designated Contact Person (Name and title, if different)		Amendment (See Part 5)	
Area Code/Phone Number <u>707-495-7438</u>	E-mail (Optional) <u>hitibbets@scity.org</u>		

2. Payor Information (For additional payors, include an attachment with the names and addresses.)

Name: Barbara Stevens

Address: 5610 Maryam's Dr. City: Santa Rosa State: CA Zip Code: 95401

3. Payee Information (For additional payees, include an attachment with the names and addresses.)

Name: Society of St. Vincent de Paul

Address: 5671 Redwood Dr. City: Robert Park State: CA Zip Code: 94928

4. Payment Information (Complete all information.)

Date of Payment: 1-26-17 (month, day, year) Amount of Payment: (In-Kind FMV) \$ 5,000 (Round to whole dollars.)

Payment Type: Monetary Donation or In-Kind Goods or Services (Provide description below.)

Brief Description of In-Kind Payment: _____

Purpose: (Check one and provide description below.) Legislative Governmental Charitable

Describe the legislative, governmental, charitable purpose, or event: Sponsorship of a charitable event. 100% of proceeds to support the Free Dining Room

5. Amendment Description and/or Comments

6. Verification

I certify, under penalty of perjury under the laws of the State of California, that to the best of my knowledge, the information contained herein is true and complete.

Executed on 2-23-17 DATE By _____ MEMBER

