

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b> HOME GARDENS SANITARY DISTRICT		Date Stamp	California Form <b>801</b> For Official Use Only
Division, Department, or Region (if applicable)			
Street Address 13538 MAGNOLIA AVENUE, CORONA, CA 92879			
Area Code/Phone Number 951-735-2368	Email ADMIN@HOMEGARDENSSD.COM	<input type="checkbox"/> Amendment (explain in comment section)	
Agency Contact (name and title) TRACEY LABONTE		Date of Original Filing: _____ (month, day, year)	

**2. Donor Name and Address**

Individual \_\_\_\_\_  Other HARPER & BURNS LLP

\_\_\_\_\_ Last Name First Name \_\_\_\_\_ Name  
 453 S. GLASSELL STREET ORANGE CA 92866  
 Address City State Zip Code  
 ATTORNEY'S OFFICE

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**

\_\_\_\_\_ Location of Travel \_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_

\_\_\_\_\_  Rail  Air  Bus  Auto  Other \_\_\_\_\_  
 Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

**3.1 (b) Payment(s) not related to travel:**

\_\_\_\_\_ 12/17/2025 \$ 65.00  
 Dates (month, day, year) Total Expenses

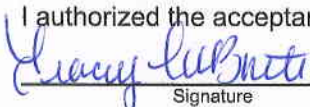
**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**  
See's Candy Assorted 2 pounds of assorted chocolates. Christmas gift to consume and enjoy.

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

LABONTE	TRACEY	GENERAL MANAGER	_____
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division
DUARTE	TANIA	ADMINISTRATIVE ASSISTANT	_____
_____ Last Name	_____ First Name	_____ Position/Title	_____ Department/Division
ALEJO	EYDEE	STAFF ASSISTANT	_____

**4. Verification**

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

 \_\_\_\_\_ TRACEY LABONTE \_\_\_\_\_ GENERAL MANAGER \_\_\_\_\_ 06/24/20  
 Signature Print Name Title (month, day, year)

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

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