

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name		Date Stamp	California Form 801 For Official Use Only
California Department of Health Care Services			
Division, Department, or Region (if applicable) Information Management Division			
Street Address 1501 Capitol Ave., Ste. 71.6001, MS 0000			
Area Code/Phone Number 916/322-5224	Email Laura.Davidson@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Laura Davidson, Staff Services Analyst			

2. Donor Name and Address

Individual _____ Other National Academy for State Health Policy

Last Name	First Name	Name
1233 20th St., NW, Suite 303	Washington	DC 20036
Address	City	State Zip/Code

501(c)(3) national independent academy of state health policymakers

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 Atlanta, GA 10/5-10/8/14

Location of Travel Dates (month, day, year)

Southwest and Delta Rail Air Bus Auto Other Atlanta Marriott Marquis

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 507.00	\$ 82.00	\$ 789.10	\$ 107.00	\$ 1,485.10
Lodging Expenses	Meal Expenses	Transportation Expenses	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.

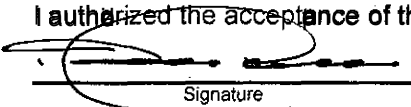
Payments are for travel expenses for Dr. Linette Scott to speak on three panels at the NASHP Annual conference which brings together state program administrators, legislators, and other health policy experts to discuss pressing and emerging health care policy issues.

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

Scott	Linette	CMIO	DHCS/IWID
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

 _____ Karen Johnson Chief Deputy Director 1/29/15

Signature Print Name Title (month, day, year)

Comment: Other Expenses include parking, rapid transit fare, incidentals, and personal auto mileage.

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