# Payment to Agency Report A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

**1. Agency Name**

California Health and Human Services

**Division, Department, or Region** (if applicable)

Department of Health Care Services

**Street Address**

1501 Capitol Avenue, Suite 6001

**Area Code/Phone Number** | **Email**

**Agency Contact** (name and title)

Date Stamp

☐ **Amendment** (explain in comment section)

**Date of Original Filing:** 04/30/15 (month, day, year)

**2. Donor Name and Address**

☐ Individual | Last Name | First Name

☑ Other ACADEMYHEALTH (Name)

1150 17th Street, NW, Suite 600 (Address) | Washington (City) | DC (State) | 20036 (Zip Code)

AcademyHealth is a 501(c)(3) non-profit engaged in health policy development.

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:**

Rene Mollow (Name) $ 1,025.00 (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) 02/08-12/2015 (Dates (month, day, year))

SouthWest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Name of Lodging Facility

$ Lodging Expenses | $ Meal Expenses | $ 1,025.00 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.**

Children's Health Policy Conference allows California a unique opportunity to work with other states to steer best practices, policy strategies, and innovation for Medi-Cal as it relates to the implementation of the Affordable Care Act, as well as informing the development of state policy

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

| Last Name | First Name | Position/Title | Department/Division |
|---|---|---|---|
| Mollow | Rene | Deputy Director | Health Care Benefits & Eligil |
| | | | |

**4. Verification**

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

Signature | Karen Johnson (Print Name) | Chief Deputy Director (Title) | 4/30/2015 (month, day, year)

Comment:

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



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