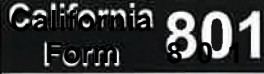


Payment to Agency Report A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name California Health and Human Services		Date Stamp	 For Official Use Only
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)		<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: <u>04/30/15</u> (month, day, year)	

2. Donor Name and Address

Individual _____ Other California Health Care Foundation

Last Name	First Name	Name
1330 21ST ST STE 100	Sacramento	CA 95814
Address	City	State Zip Code

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:

<u>Rene Mollow</u>	\$ <u>1,704.78</u>	_____	\$ _____
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 02/08-12/2015

Location of Travel Dates (month, day, year)

Supreme Shuttle Rail Air Bus Auto Other Helix

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ <u>716.78</u>	\$ <u>110.00</u>	\$ <u>78.00</u>	\$ <u>800.00</u>	\$ <u>1,704.78</u>
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: 02/08-12/2015 \$ _____

Dates (month, day, year) Total Expenses

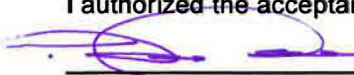
3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
 National Health Policy Conference (HPC) and Children's HPC allow California a unique opportunity to work with other states to steer best practices, policy strategies, and innovation for Medi-Cal as it relates to the implementation of the Affordable Care Act, as well as informing the development of

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

<u>Mollow</u>	<u>Rene</u>	<u>Deputy Director</u>	<u>Health Care Benefits & Eligil</u>
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.

	<u>Karen Johnson</u>	<u>Chief Deputy Director</u>	<u>04/30/2015</u>
Signature	Print Name	Title	(month, day, year)

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

Clear Page