Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

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)

☐ **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 — California Health Care Foundation (Name)

1330 21ST ST STE 100 (Address) | Sacramento (City) | CA (State) | 95814 (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:

Rene Mollow (Name) | $ 1,704.78 (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))

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

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$ 716.78	$ 110.00	$ 78.00	$ 800.00	$ 1,704.78

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)

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

Comment:

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

FPPC Form 801 (Jan/14)
advice@fppc.ca.gov

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