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 (916)552-9644

Email carey.montgomery@dhcs.ca.gov

Agency Contact (name and title)

Carey Montgomery, Executive Assistant

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

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other California Endowment and California HealthC; (Name)

4800 2nd Avenue, Suite 2600 (Address) Sacramento (City) CA (State) 95817 (Zip Code)

Institute for Population Health Improvement

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) $110.69 (Amount) _____ (Name) $ _____ (Amount)

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment Dallas, Tx (Location of Travel) 4/22-23/2015 (Dates (month, day, year))

Personal, Taxi (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☑ Other (Check Applicable Boxes) _____ (Name of Lodging Facility)

$ _____ (Lodging Expenses) $ 9.93 (Meal Expenses) $ 100.76 (Transportation Expenses) $ _____ (Other Expenses) $ 110.69 (Total Expenses)

3.1 (b) Payment(s) not related to travel; 4/22-23/2015 (Dates (month, day, year)) $ 110.69 (Total Expenses)

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Ground transportation, meals, and parking. NOSLO Advisory Group In-Person Meeting.

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.

WMM (Signature) Rene Mollow, MSN, RN (Print Name) Deputy Director, Health Care Be (Title) 07/14/15 (month, day, year)

Comment:

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

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