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 NATIONAL ACADEMY FOR STATE HEALTH (Name)

Address	City	State	Zip Code
10 Free Street, 2nd Floor	Portland	ME	04112

Health Services and Policy Research

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
Rene Mollow	$ 460.00		$

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

3.1 (a) Travel Payment

Location of Travel: Dallas, Tx

Dates (month, day, year): 4/22-23/2015

Transportation Provider: ______

☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Name of Lodging Facility: ______

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$ 84.00	$	$ 376.00	$	$ 460.00

3.1 (b) Payment(s) not related to travel:

Dates (month, day, year): 4/22-23/2015

Total Expenses: $ 460.00

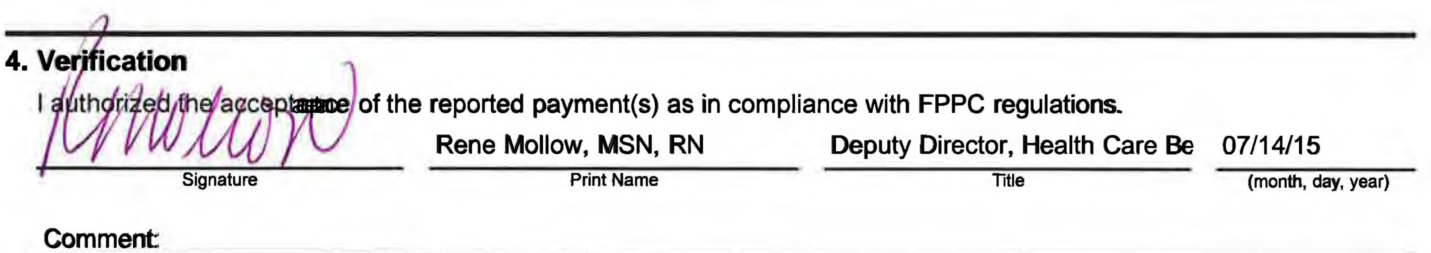
3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Commercial airfare and lodging to attend the 2015 National Organizations for State and Local Officials 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.

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

Comment:

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

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