

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name California Health and Human Services		Date Stamp	California Form 801 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 (916) 445-3859	Email shirley.fong@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Shirley Fong, Training Manager			

2. Donor Name and Address

Individual _____ Other California HealthCare Foundation

Last Name: _____ First Name: _____ Name: _____
 1438 Webster Street, Suite 400 San Francisco CA 94612
 Address City State Zip Code
 Non-profit CHCF support ideas and innovations that improve quality, increase efficiency and lower costs of health care
 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

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

3.1 (a) Travel Payment South Lake Tahoe, CA 05/18/2014

Location of Travel Dates (month, day, year)

Transportation Provider Rail Air Bus Auto Other Forest Suites Resort
 Check Applicable Boxes Name of Lodging Facility

\$ _____	\$ _____	\$ 116.48	\$ _____	\$ 116.48
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: _____ \$ _____

Dates (month, day, year) Total Expenses

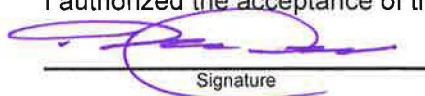
3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
 Attend Boot Camp which is designed for New Medicaid Directors and Senior Staff.

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

Dodson	Anastasia	Ass. Director for Policy	Health Care Services
_____	_____	_____	_____
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.


 Karen J. Johnson Chief Deputy Director 7/30/14
 Signature Print Name Title (month, day, year)

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