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) 445-3859

Email
shirley.fong@dhcs.ca.gov

Agency Contact (name and title)
Shirley Fong, Training Manager

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

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

2. Donor Name and Address

☐ Individual ____________ Last Name ____________ First Name

☑ Other National Association of Medicaid Directors (Name)

Address	City	State	Zip Code
444 North Capitol Street, Suite 524	Washington	DC	20001

The National Association of Medicaid Directors (NAMD) is a bipartisan, professional, nonprofit organization of representati

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

Location of Travel: South Lake Tahoe, CA

Dates (month, day, year): 05/18-20/2014

Transportation Provider: ____________

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

Name of Lodging Facility: Forest Suites Resort

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$204.12	$11.00	$135.52	$	$350.64

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.

It is a requirement that the Director attend the these conferences as a board member.

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

Last Name	First Name	Position/Title	Department/Division
Douglas	Toby J.	Director	Health Care Services

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]	Karen J. Johnson	Chief Deputy Director	7/30/14

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

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