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 California HealthCare Foundation (Name)

1438 Webster Street, Suite 400 (Address) San Francisco (City) CA (State) 94612 (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 (Location of Travel) 05/18/2014 (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☑ Auto ☐ Other (Check Applicable Boxes) Forest Suites Resort (Name of Lodging Facility)

$_____ (Lodging Expenses) $_____ (Meal Expenses) $109.76 (Transportation Expenses) $_____ (Other Expenses) $109.76 (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)

Last Name	First Name	Position/Title	Department/Division
Giy	Oksana	Health Care Reform Advisc	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)
	Karen J. Johnson	Chief Deputy Director	7/30/14

Comment:

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

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