# 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)

05/17-18/2014 (Dates (month, day, year))

_____ (Transportation Provider)

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

Forest Suites Resort (Name of Lodging Facility)

| $102.06 | $34.00 | $89.60 | $5.00 | $230.66 |
|---|---|---|---|---|
| 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)

| Last Name | First Name | Position/Title | Department/Division |
|---|---|---|---|
| Perez | Marlies | Chief, SUD Compliance | 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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