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)552-8379

Email: Shirley.fong@dhcs.ca.gov

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

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

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

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other: American Public Human Services Assn. (Name)

1133 19th St. NW, Ste. 400 (Address) | Washington (City) | DC (State) | 20036 (Zip Code)

APHSA is a bipartisan, non-profit organization representing state and local human services agencies

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

Philadelphia, PA (Location of Travel) | 08/27/15-09/02/15 (Dates (month, day, year))

Southwest Airlines (Transportation Provider) | ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Philadelphia Marriott Downtown (Name of Lodging Facility)

$554.40 Lodging Expenses | $_____ Meal Expenses | $451.00 Transportation Expenses | $_____ Other Expenses | $1,005.40 Total Expenses

3.1 (b) Payment(s) not related to travel: 8/30/15-09/2/15 (Dates (month, day, year)) | $ 500.00 (Total Expenses)

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

Airfare, lodging for 3 nights, and conference registration fee to attend the American Public Human Services Association/IT Solutions Management for Human Services Conference

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

Last Name	First Name	Position/Title	Department/Division
Hayes	Melody	Deputy Director	CA-MMIS Division

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Original Signature on File (Signature) | Karen Johnson (Print Name) | Chief Deputy Director (Title) | _____ (month, day, year)

Comment:

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

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