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	Email
(916) 445-3859	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) Oakland (City) CA (State) 94612 (Zip Code)

Nonprofit organization that commonly provides information and training related to health care and health care related data

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:

California HealthCare Foundation (Name) $199.00 (Amount)

Federal Funds (Name) $1,791.00 (Amount)

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

3.1 (a) Travel Payment

Denver, Colorado (Location of Travel)

08/17/14 - 08/21/14 (Dates (month, day, year))

United Airlines (Transportation Provider)

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

_____ (Name of Lodging Facility)

$759.62	$72.00	$723.44	$	$1,990.06
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel:

08/17/14 (Dates (month, day, year)) $ 435.00 (Total Expenses)

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

CMS provided training to Medicaid agencies on various topics, developing the Medicaid enterprise, strategies for effectively and efficiently governing and managing the enterprise, achieving federal compliance, etcc., through application of the CMS MITA Frameworks.

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

Last Name	First Name	Position/Title	Department/Division
Dixon	Debra	Data Process Mgr II	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 Johnson	Chief Deputy Director	10/30/2014

Comment:

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

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