

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name

Health and Human Services Agency

Division, Department, or Region (if applicable)

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

Date Stamp

California Form 801

For Official Use Only

Amendment (explain in comment section)

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

2. Donor Name and Address

Individual

Last Name

First Name

Other

The Henry J. Kaiser Family Foundation

Name

2400 Sand Hill Road

Menlo Park

CA

94025

Address

City

State

Zip Code

Kaiser is a non-profit organization focusing on the major health care issues facing the U.S., as well as the U.S. role in glob

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

Washington, DC

Location of Travel

February 18-19, 2014

Dates (month, day, year)

United Airlines

Transportation Provider

Rail

Air

Bus

Auto

Other

Renaissance Washington

Name of Lodging Facility

\$ 210.68

Lodging Expenses

\$ 53.00

Meal Expenses

\$ 699.43

Transportation Expenses

\$

Other Expenses

\$ 963.11

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.

To participate on a panel for the Kaiser Family Foundation and the Blue Shield of California Foundation entitled "Uninsured at the Starting Line: A Spotlight on California"

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

Douglas

Toby

Director

Last Name

First Name

Position/Title

Department/Division

Last Name

First Name

Position/Title

Department/Division

4. Verification

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

Signature

Print Name

Title

(month, day, year)

Comment:

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