Payment to Agency R	eport A Public L	ocument	PAYMENT TO AGENCY REPORT
1. Agency Name		Date Stamp	California 201
Health and Human Services Agency			Form PV 1
Division, Department, or Region (if applicable)			For Official Use Only
Health Care Services			
Street Address			
1501 Capitol Avenue, Suite	e 6001		
Area Code/Phone Number	Email		
(916))445-3859	shirley.fong@dhcs.ca.gov	Amendment ((explain in comment section)
Agency Contact (name and title)		Date of Original F	Filina:
Shirley Fong, Training Mar			(month, day, year)
2. Donor Name and Addre	ess .		
☐ Individual		_ ☑ Other ————————————————————————————————————	nors Association (NGA)
Last Name	First Name	_	Name
444 N. Capitol Street, NW Address	Washington		OC 200011 ate Zip Code
		Sit	ale Zip Gude
	nization of the nation's governors	N - II	
If "Other" is marked, describe the entity	's business activity (if business) or its nature and i	interests	
If applicable.	identify the name of each source and the	ne amount(s) received by the don	or for this payment:
	,		
Name	\$	Name	\$\$
Payment Information (Complete Sections 3.1 (a or b)	2 2 2 2 1	
			anuary 13-15, 2014
3.1 (a) Travel Payment	Washington, DC Location of Travel		Dates (month, day, year)
United Airlines		10	
Transportation Provider		Bus □ Auto □ Other <u>₩</u>	/ Washington B6 Name of Lodging Facility
- Windowskie	Check Applicable	Boxes	1,813.40
\$ <u>421.36</u>	\$ 1,269.04 \$	\$	\$- Total Expenses
Lodging Expenses	Meal Expenses Tripmsportation E	Expenses Other Expenses	Total Expenses
3.1 (b) Payment(s) not re	elated to travel:	Dates (marth day year)	Total Expenses
		Dates (month, day, year)	
3.2. Payment Description	n. Provide a specific description	of the payment and its ager	ncy purpose and use.
To participate in a me	eting entitled "Learning from I	Each Other: The Roles of	f States in Transferring
their Health Systems"			
•			
3.3 Identify the officials	who used the payment in Section	3 1 (See instructions)	
			Health Core Financine
Wurden	Meredith	Assistant Deputy Director	Health Care Financing
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division
4. Verification			
I authorized the acceptance	e of the reported payment(s) as in o	compliance with FPPC regulat	/
Tope ado	Con - Ka	rea Johnson	4/30/14
Signature	Print Name	Title	(month, day, year)
Comment:			
(Use this space or an attachment	for any additional information)		EDDC Form 904 / lon/44

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