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 National Association of Medicaid Director (Name)

444 North Capitol St, Suite 524 (Address) Washington (City) DC (State) 20001 (Zip Code)

The National Association of Medicaid Directors is an entity that was created in large part to help Medicaid directors develo

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

Los Angeles, CA (Location of Travel) 12/10-12/12/2014 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Manhattan Beach Hotel (Name of Lodging Facility)

$_____ 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.

See attached

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

Last Name	First Name	Position/Title	Department/Division
Baylor	Karen	Deputy Director, MHSUD	Health Care Services
See Attached for Full List			

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 Johnson	Chief Deputy Director	1/29/2015

Comment:

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

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National Association of Medicaid Directors
Behavorial Health Integration Workshop
December 10-14, 2014
Manhattan Beach Marriott
1460 Parkview Avenue
Manhattan Beach, CA 90266

Attendee Name	Air	Lodging Expense	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
Baylor, Karen	286.42	303.90	105.00	112.83	10.00 (Incidentals)	818.15
Braeger, Don	466.20	303.60	82.00	13.66	10.00 (Incidentals)	875.46
Brooks, Sarah	DID NOT ATTEND					
Cantwell, Mari	DID NOT ATTEND					
Grealish, Brenda	184.20	303.90	116.00		13.95 (Incidentals)	618.05
Ketch, Hannah	211.20	322.43	58.06	43.64	50.00 (Baggage Fee) 5.00 (Incidentals)	690.33