

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name

California Department of Health Care Services

Division, Department, or Region (if applicable)

Information Management Division

Street Address

1501 Capitol Ave., Ste. 71.6001, MS 0000

Area Code/Phone Number

916/322-5224

Email

Laura.Davidson@dhcs.ca.gov

Agency Contact (name and title)

Laura Davidson, Staff Services Analyst

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

National Academy for State Health Policy

Name

1233 20th St., NW, Suite 303

Washington

DC

20036

Address

City

State

Zip Code

501(c)(3) national independent academy of state health policymakers

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

Atlanta, GA

10/5-10/8/14

Location of Travel

Dates (month, day, year)

Southwest and Delta

Transportation Provider

Rail

Air

Bus

Auto

Other

Atlanta Marriott Marquis

Name of Lodging Facility

\$ 507.00

Lodging Expenses

\$ 82.00

Meal Expenses

\$ 789.10

Transportation Expenses

\$ 107.00

Other Expenses

\$ 1,485.10

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.

Payments are for travel expenses for Dr. Linette Scott to speak on three panels at the NASHP Annual conference which brings together state program administrators, legislators, and other health policy experts to discuss pressing and emerging health care policy issues.

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

Scott

Linette

CMIO

DHCS / IMD

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

Karen Johnson

Print Name

Chief Deputy Director

Title

1/29/15 (month, day, year)

Comment: Other Expenses include parking, rapid transit fare, incidentals, and personal auto mileage.

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