Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

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	Email
916/322-5224	Laura.Davidson@dhcs.ca.gov

Agency Contact (name and title)

Laura Davidson, Staff Services Analyst

☐ **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 (Address) Washington (City) DC (State) 20036 (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 (Location of Travel) 10/5-10/8/14 (Dates (month, day, year))

Southwest and Delta (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Atlanta Marriott Marquis (Name of Lodging Facility)

$507.00	$82.00	$789.10	$107.00	$1,485.10
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.

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)

Last Name	First Name	Position/Title	Department/Division
Scott	Linette	CMIO	DHCS / IMD

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	1/29/15

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

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

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