

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name California Health and Human Services		Date Stamp	California Form 801 For Official Use Only
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	<input type="checkbox"/> Amendment (explain in comment section)	
Agency Contact (name and title) Shirley Fong, Training Manager		Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

Individual _____ Other AcademyHealth

_____ Last Name First Name Name

1150 17th St., NW, Suite 600 Washington DC 20036

Address City State Zip Code

Seeks to improve health and health care by generating new knowledge and moving knowledge into action.

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 Chicago, Illinois 10/22/14 - 10/24/14

_____ Location of Travel Dates (month, day, year)

Southwest Airlines Rail Air Bus Auto Other Hotel Palomar, Chicago

Transportation Provider Check Applicable Boxes 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.

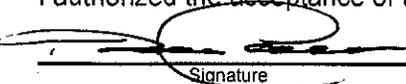
See attached

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

Soe	Wendy	Policy Analyst	Health Care Services
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
See Attached for Full List			
_____	_____	_____	_____
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.

 Karen Johnson Chief Deputy Director 1/29/15

Signature Print Name Title (month, day, year)

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

Payment Reform: Honing the Models and Pushing the Boundaries
October 23-25, 2014
Chicago, Illinois

Attendee Name	Air	Lodging Expense *	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
Soe, Wendy	616.20	556.34	85.78	75.99		777.97
Williams, Pilar	616.20	556.34	76.86	92.40	10.00 (Incidentals)	795.46

- Paid for by conference