

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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
Email
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: 04/30/15 (month, day, year)

2. Donor Name and Address
Individual Other
California Health Care Foundation
1330 21ST ST STE 100 Sacramento CA 95814
501(c)(3) non-profit engaged in health policy development.
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:
Rene Mollow \$ 1,704.78

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Washington DC
02/08-12/2015
Supreme Shuttle
Helix
\$ 716.78 \$ 110.00 \$ 78.00 \$ 800.00 \$ 1,704.78
3.1 (b) Payment(s) not related to travel:
02/08-12/2015 \$

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
National Health Policy Conference (HPC) and Children's HPC allow California a unique opportunity to work with other states to steer best practices, policy strategies, and innovation for Medi-Cal as it relates to the implementation of the Affordable Care Act, as well as informing the development of

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Mollow Rene Deputy Director Health Care Benefits & Eligibility
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
Signature Print Name Title (month, day, year) 4/30/2015

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