

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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)552-8379	Email shirley.fong@dhs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Shirley Fong, Manager			

**2. Donor Name and Address**

Individual \_\_\_\_\_  Other American Public Human Services Assn.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 1133 19th St. NW, Ste. 400 Washington DC 20036  
 Address City State Zip Code

APHSA is a bipartisan, non-profit organization representing state and local human services agencies

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** Philadelphia, PA 08/27/15-09/02/15  
 Location of Travel Dates (month, day, year)

Southwest Airlines  Rail  Air  Bus  Auto  Other Philadelphia Marriott Downtown  
 Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 554.40 \$ \_\_\_\_\_ \$ 451.00 \$ \_\_\_\_\_ \$ 1,005.40  
 Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

**3.1 (b) Payment(s) not related to travel:** 8/30/15-09/2/15 \$ 500.00  
 Dates (month, day, year) Total Expenses

**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**  
 Airfare, lodging for 3 nights, and conference registration fee to attend the American Public Human Services Association/IT Solutions Management for Human Services Conference

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

Hayes	Melody	Deputy Director	CA-MMIS Division
_____	_____	_____	_____
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.

Original Signature on File	Karen Johnson	Chief Deputy Director	_____
Signature	Print Name	Title	(month, day, year)

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