

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 ACADEMYHEALTH
Last Name First Name
1150 17th Street, NW, Suite 600 Washington DC 20036
Address City State Zip Code
AcademyHealth is a 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 \$ 1,025.00
Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Washington DC
Location of Travel
02/08-12/2015
Dates (month, day, year)
SouthWest
Transportation Provider
Rail Air Bus Auto Other
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.
Children's Health Policy Conference allows 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 state policy

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

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

