

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b> California Health and Human Services		Date Stamp	<b>California Form 801</b> 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 <u>(916) 552-9644</u>	Email <u>Carey.montgomery@dhcs.ca.gov</u>	<input type="checkbox"/> Amendment (explain in comment section)	
Agency Contact (name and title) <u>Carey Montgomery, Executive Assistant</u>		Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

Individual \_\_\_\_\_  Other NATIONAL ACADEMY FOR STATE HEALTH

Last Name First Name Name  
 10 Free Street, 2nd Floor Portland ME 04112  
 Address City State Zip Code  
 Health Services and Policy Research

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:

<u>Rene Mollow</u>	\$ <u>460.00</u>	_____	\$ _____
Name	Amount	Name	Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

**3.1 (a) Travel Payment** Dallas, Tx 4/22-23/2015  
 Location of Travel Dates (month, day, year)

\_\_\_\_\_  
 Transportation Provider  Rail  Air  Bus  Auto  Other  
 Check Applicable Boxes Name of Lodging Facility

\$ 84.00 \$ \_\_\_\_\_ \$ 376.00 \$ \_\_\_\_\_ \$ 460.00  
 Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

**3.1 (b) Payment(s) not related to travel:** 4/22-23/2015 \$ 460.00  
 Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Commercial airfare and lodging to attend the 2015 National Organizations for State and Local Officials Advisory Group In-Person Meeting.

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

<u>Mollow</u>	<u>Rene</u>	<u>Deputy Director</u>	<u>Health Care Benefits &amp; Eligibility</u>
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.

*Rene Mollow* Rene Mollow, MSN, RN Deputy Director, Health Care Be 07/14/15  
 Signature Print Name Title (month, day, year)

Comment:

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

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