

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	Email		
Agency Contact (name and title)		<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

Individual _____ Other _____

Last Name: 444 North Capitol Street, NW
 First Name: Washington
 City: DC
 State: 20001
 Zip Code:

The National Governors Association (NGA) is the bipartisan organization of the nation's governors.

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 Raleigh, NC April 6-8, 2015

Location of Travel: Raleigh, NC Dates (month, day, year): April 6-8, 2015

United Airlines Rail Air Bus Auto Other Hyatt Place

Transportation Provider: United Airlines Check Applicable Boxes Name of Lodging Facility: Hyatt Place

\$ _____	\$ _____	\$ 1,120.00	\$ _____	\$ 1,120.00
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.
To attend the NGA Learning Lab: Substance Use Prevention and Treatment meeting in Raleigh, NC.

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

Logan	Julia	Quality Officer	Office of the Med Director
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.


 Karen Johnson
 Signature Print Name

Chief Deputy Director
 Title

7/20/15
 (month, day, year)

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

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