

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
(916) 445-3859
Email
shirley.fong@dhcs.ca.gov
Agency Contact (name and title)
Shirley Fong, Training Manager
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual Other
California HealthCare Foundation
1438 Webster Street, Suite 400 Oakland CA 94612
Address City State Zip Code
Nonprofit organization that commonly provides information and training related to health care and health care related data
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:
California HealthCare Foundation \$199.00 Federal Funds \$1,791.00
Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Denver, Colorado 08/17/14 - 08/21/14
Location of Travel Dates (month, day, year)
United Airlines Rail Air Bus Auto Other
Transportation Provider Check Applicable Boxes Name of Lodging Facility
\$759.62 \$72.00 \$723.44 \$1,990.06
Lodging Expenses Meal Expenses Transportation Expenses Other Expenses Total Expenses

3.1 (b) Payment(s) not related to travel:
08/17/14 \$435.00
Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
CMS provided training to Medicaid agencies on various topics, developing the Medicaid enterprise, strategies for effectively and efficiently governing and managing the enterprise, achieving federal compliance, etc., through application of the CMS MITA Frameworks.

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Dixon Debra Data Process Mgr II Health Care Services
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 10/30/2014
Print Name Title (month, day, year)

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

