

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name
Health and Human Services Agency
Division, Department, or Region (if applicable)
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 The Henry J. Kaiser Family Foundation
Last Name First Name Name
2400 Sand Hill Road Menlo Park CA 94025
Address City State Zip Code

Kaiser is a non-profit organization focusing on the major health care issues facing the U.S., as well as the U.S. role in glob
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
Washington, DC Location of Travel
February 18-19, 2014 Dates (month, day, year)
United Airlines Transportation Provider
Rail Air Bus Auto Other Check Applicable Boxes
Renaissance Washington Name of Lodging Facility
\$ 210.68 \$ 53.00 \$ 699.43 \$ Other Expenses \$ 963.11
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 participate on a panel for the Kaiser Family Foundation and the Blue Shield of California Foundation entitled "Uninsured at the Starting Line: A Spotlight on California"

3.3. Identify the officials who used the payment in Section 3.1 (See instructions)
Douglas Toby Director
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 CDD Title
4/30/14 (month, day, year)

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