| Department of Health Care Services       Form CUL         Division, Department, or Region (resplantion)       Administration Division, Human Resources Branch       For Othola Use Only         Administration Division, Human Resources Branch       Image: Complete Services       Image: Complete Services       Image: Complete Services         P.O. Box 997411, MS 1300       ConflictofInterest@dhcs.ca.gov       Amendment (explain in comment section)       Date of Orginal Filing:(month, day, year)         Conflict of Interest Filing Officer       ConflictofInterest@dhcs.ca.gov       Name       Name         20 American Metro Blvd, Suite 119       Hamilton       Name       Name         20 American Metro Blvd, Suite 119       Hamilton       Name       Xap Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       Image: Xap Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       Image: Xap Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       Image: Xap Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       Image: Xap Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       I  | Payment to Agency Re                        | eport                        | A Public Do                  | cument         |  |              | PAYMENT TO AGENCY REPORT  |
|---|---|------------------------------|------------------------------|----------------|--|--------------|---------------------------|
| Department, or Region (#applicable)         Administration Division, Human Resources Branch         Street Address         P.O. Box 997411, MS 1300         Area Code/Phone Number         [916] 552-8270       ConflictofInterest@dhcs.ca.gov         Agency Contact (unue and the context (unue and the context))         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Hamilton       N       08619         200 American Metro Blvd, Suite 119       Last Name       Name       Anount         3.1 (a) ravel Payment       Washington, DC       Name       Name       Anount     <  | 1. Agency Name                              |                              |                              |                | Date Sta                               | amp          | California 801            |
| Durision, Department, or Kegion (registicate)         Administration Division, Human Resources Branch         Street Address         P.O. Box 997411, MS 1300         Area Code/Phone Number         [916) 552-8270         Conflict of Interest Filing Officer         2. Donor Name and Address         Individual         Last Name         200 American Metro Bivd, Suite 119         Hamilton         Address         Conflict of Interest Filing Officer         200 American Metro Bivd, Suite 119         Hamilton         NU       08619         Address         City       State         Zip Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly         #*Other's marked, dearche the entry's bulness activity of bulness or its nature and interests         Image       Annount         Name       Annount         Name       Annount         Name       Annount         Name       Annount         State       In/07/15-10/08/15         Dates (month, day, year)       Dates (month, day, year)         It applicable, identify the name of eacth source and the amount(s) received by the donor for this payment:  |   |                              |                              |                |  |              |                           |
| Street Address       P.O. Box 997411, MS 1300         Area Code/Phone Number       Email         (916) 552-8270       ConflictofInterest@dhcs.ca.gov         Deter Original Filing:       (month.day.year)         Deter Original Filing:       (month.day.year)         Donor Name and Address       Other         Individual       Last Name         20 American Metro Blvd, Suite 119       Hamilton         Name       Name         200 American Metro Blvd, Suite 119       Hamilton         Name       Other         Cher is marked, describe the entity business activity of business on its nature and interests.         If opplicable, identify the name of each source and the amount(s) received by the donor for this payment:         Name       Samount         Name       Amount         Name       Sata         Name       Amount         Name       Amount         N  |   |                              |                              |                |  |              | For Official Ose Offiy    |
| Area Code/Phone Number       Email       ConflictofInterest@dhcs.ca.gov         Agency Contact (mms and Bile)       ConflictofInterest@dhcs.ca.gov       Date of Original Filing:       (month, day, year)         2. Donor Name and Address       Individual       East Name       © Other       Center for Health Care Strategies (CHCS)         2.0 American Metro Bivd, Suite 119       Hamilton       NJ       08619         Address       City       State       2p Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly if Other is mature and interests.       If applicable, identify the name of each source and the amount(s) received by the donor for this payment:         Name       S_mount       Name       Amount         3.1 (a) Travel Payment       Washington, DC       10/07/15-10/08/15       Dates (month, day, year)         US Airways       Transportation Provider       § 845.59       12.288.19       Total Expenses         3.1 (b) Payment(s) not related to travel:       S       Total Expenses       12.881.9       Total Expenses         3.1 (b) Payment(s) not related to travel:       Dates (month, day, year)       Total Expenses       12.881.9       Total Expenses         3.1 (b) Payment(s) not related to travel:       East (month, day, year)       Total Expenses       12.881.19       Total Expen   |   |                              |                              |                |  |              |                           |
| (916) 552-8270       ConflictofInterest@dhcs.ca.gov       Amendment (explain in comment section)         Agency Contact (name and title)<br>Conflict of Interest Filing Officer       Date of Original Filing:<br>(month, day, year)         20 Donor Name and Address       Other       Center for Health Care Strategies (CHCS)         200 American Metro Bivd, Suite 119       Hamilton       NJ       08619         200 American Metro Bivd, Suite 119       Hamilton       NJ       08619         Address       City       Bate       2p Code         A national nonprofit health policy resource center focused on advancing access, quality, and cost-effectiveness in publicly       PC/Other' is marked, deache the entity's business activity of business) or its nature and interests.         Image: Second  | P.O. Box 997411, MS 1300                    |                              |                              |                |  |              |                           |
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| Location of Travel       Dates (month, day, year)         US Airways       Rail       Air       Bus       Auto       Other       The Donovan Hotel         Name of Lodging Facenses       S       Set5.59       Set5.59 </th <th>•</th> <th>-</th> <th></th> <th>.2, 0.0)</th> <th></th> <th>10/07/15</th> <th>5-10/08/15</th>  | •   | -                            |                              | .2, 0.0)       |  | 10/07/15     | 5-10/08/15                |
| Transportation Provider       Rail       Bus       Auto       Other       Name of Lodging Facility         \$ <ul> <li>Auto</li> <li>Check Applicable Boxes</li> <li>Section (Title</li> <li>Name of Lodging Facility</li> <li>Name of Lodging Facility</li></ul>   | 5.1 (d) Havel Payment                       |                              |                              |                | -                                      |              |                           |
| Transportation Provider       Check Applicable Boxes       Name of Lodging Facility         \$ <ul> <li>422.51</li> <li>Lodging Expenses</li> <li></li></ul>  | US Airways                                  | 🗖 Rail                       | 🖂 Air 🗖 Bus                  |                | ∩ Other                                | The Dor      | ovan Hotel                |
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| KennedyBrianDental Program ConsultMedi-Cal Dental ServicesLast NameFirst NamePosition/TitleDepartment/DivisionLast NameFirst NamePosition/TitleDepartment/Division  | California project team                     | participation in t           | the CHCS' Med                | licaid Ora     | al Health Le                           | earning (    | Collaborative.            |
| KennedyBrianDental Program ConsultMedi-Cal Dental ServicesLast NameFirst NamePosition/TitleDepartment/DivisionLast NameFirst NamePosition/TitleDepartment/Division  |   |                              |                              |                |  |              |                           |
| KennedyBrianDental Program ConsultMedi-Cal Dental ServicesLast NameFirst NamePosition/TitleDepartment/DivisionLast NameFirst NamePosition/TitleDepartment/Division  |   |                              |                              |                |  |              |                           |
| Last Name     First Name     Position/Title     Department/Division       Last Name     First Name     Position/Title     Department/Division   | 3.3. Identify the officials w               | ho used the payn             | nent in Section 3            | 1 (See instrue | ctions)                                |              |                           |
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|   | Last Name                                   | Last Name First Name         |                              | Posi           | Position/Title                         |              | Department/Division       |
|   |   |                              |                              |                |  |              |                           |
|   | Last Name                                   | Last Name First Name         |                              | Posi           | Position/Title                         |              | Department/Division       |
|   |   |                              |                              |                |  |              | -p                        |
|   | 4. Verification                             |                              |                              |                |  |              |                           |
|   |   | of the reported per          | (mont(a) as is as            | nlianaa wi     |  | lations      |                           |
| I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations. ORIGINAL ON FILE Karen Johnson Chief Deputy Director   |   |                              | . ,                          |                | •                                      |              |                           |
| ORIGINAL ON FILE         Karen Johnson         Chief Deputy Director           Signature         Print Name         Title         (month, day, year)  |   |                              |                              |                |  |              | (month, day, year)        |

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



# Payment to Agency ReportInstructionsA Public Document



This form is used to report certain payments received by state and local government agencies. It includes:

- a payment for an official's travel expenses for the purpose of facilitating the public's business in lieu of a payment using agency funds; and
- a payment that would otherwise be considered a gift or income to the benefiting official, but is instead accepted on behalf of the agency.

FPPC Regulations 18944 and 18950.1 provide a procedure that state and local agencies may use to disclose payments used for agency purposes and paid by a third party. The regulations' reporting procedures provide an alternative means to disclose a payment that may otherwise be considered income or a gift to a benefitting employee and subject to reporting on a Statement of Economic Interest, Form 700.

## When and Where to File

An agency accepting a payment pursuant to Regulation 18944 and 18950.1 must complete Form 801 for each payment received regardless of the amount. The form must be maintained as a public document. If payments aggregate \$2,500 or more in a calendar quarter, website posting is required.

## Website Posting:

## **State Agencies**

Within 30 days after the end of a calendar quarter if aggregated reported payments, for travel and non-travel purposes, total \$2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC which will also post the information.

## **Local Agencies**

The website posting rules differ for travel and non-travel payments.

#### Travel

Within 30 days after the end of a calendar quarter if aggregated reported payments total \$2,500 or more:

- the agency must post the reports (or a report summary) on the agency website; and
- forward the information to the FPPC.

## **Payments Not Related to Travel**

The agency's filing officer for Statement of Economic Interests, Form 700, must receive the report. Within 30 days after the end of a calendar quarter if aggregated reported payments total \$2,500 or more, the local agency must post the information on the local agency website. A report is not sent to the FPPC unless the agency does not have a website.

Postings must be displayed in a prominent manner and easily accessible. Reports may be posted earlier.

**FPPC**: Statements should be emailed to form801@fppc.ca.gov. Statements may also be mailed to 428 J Street, Suite 620, Sacramento, CA, 95814 or faxed to (916) 322-3711.

# Part 1. Agency Identification

List the agency's name and address and the name of an agency contact. Mark the amendment box if changing any information on a previously filed form and include the date of the original filing.

### Part 2. Donor Information

Disclose the name and address of the donor. If the donor is not an individual, identify the business activity or nature and interests of the entity.

If the donor received funds from other sources that were used in connection with the payment, disclose the name and payment information for each source.

## Part 3. Payment Information

Expenses may be rounded to whole dollars.

**Section 3.1.a.** Itemize travel payments including departure and return dates. Complete all fields, use "n/a" appropriately. Total the expenses for items such as taxi rides, gratuities, and rental cars in the "other" field and describe in the comments section.

Section 3.1.b. Report agency payments that are not travel related.

## Section 3.2. Description

All payments must include a specific description of the use of the payment and the intended purpose for agency business. For example, a travel payment may read: Travel to attend an EPA co-sponsored solar energy seminar in Washington D.C.

## Section 3.3. Identify Officials

Travel Payments: The name of the position/title and department of each official who used the payment is required. List the official's name if he/she is an elected or appointed official. It is not required to list the names of other officials, rather insert "n/a." Do not leave blank.

Non-Travel Payments: The name, position/title and department of the agency official who used the payment must be identified. All officials' names are required.

#### Part 4. Verification

Verification of travel payments must be signed by an authorized agency official. Such individuals are those who have the authority to approve similar travel payments when made with agency funds.

Verification of non-travel payments must be signed by the agency head.