Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT
California Form 801
For Official Use Only

Date Stamp

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration Division, Human Resources Branch

Street Address

P.O. Box 997411, MS 1300, Sacramento, CA 95899-7411

Area Code/Phone Number	Email
(916) 552-8270	ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: 07/19/16 (month, day, year)

2. Donor Name and Address

☐ Individual ______ Last Name ______ First Name

☑ Other Blue Shield of California Foundation (BSCF) — Name

Address	City	State	Zip Code
50 Beale Street	San Francisco	CA	94105

BSCF strives to improve the lives of all Californians by making health care accessible, effective, and affordable.

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

Location of Travel: ______ Dates (month, day, year): ______

Transportation Provider: ______

☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other — Check Applicable Boxes

Name of Lodging Facility: ______

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$	$	$	$	$

3.1 (b) Payment(s) not related to travel:

Dates (month, day, year): June 9, 2016
Total Expenses: $ 58,500.00

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

To support the Department of Health Care Services in catalyzing innovations in policy and payment through the delivery of the DHCS Academy, a custom-designed, nine-month leadership and development program for managers across DHCS.

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

Last Name	First Name	Position/Title	Department/Division
Kent	Jennifer	Director	DHCS

4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

Signature	Print Name	Title	(month, day, year)
ORIGINAL ON FILE	Karen Johnson	Chief Deputy Director	07/19/16

Comment:

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