Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Covered California

Division, Department, or Region (if applicable)

Executive

Street Address

1601 Exposition Blvd., Sacramento, CA 95819

Area Code/Phone Number

(916)228-8608

Email

allison.pease@covered.ca.gov

Agency Contact (name and title)

Allison Pease, Attorney

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

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual — Last Name _____ First Name _____

☑ Other — Yale University (Name)

60 College Street (Address) | New Haven (City) | CT (State) | 06510 (Zip Code)

Academic institution.

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

New Haven, CT (Location of Travel) | 4/10/18 - 4/17/18 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) _____ (Name of Lodging Facility)

$_____ (Lodging Expenses) $_____ (Meal Expenses) $_____ (Transportation Expenses) $_____ (Other Expenses) $1,462.00 (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.

Reimburse travel to speak at 2018 Yale Healthcare Conference for School of Management and Health Professionals School to discuss pressing issues in health care industry, directly related to CC's functions to operate health ins. exchange and improve access to quality, affordable health care.

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

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

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

[signature] (Signature) | Karen Johnson (Print Name) | Chief Deputy Exec. Director (Title) | 9/13/18 (month, day, year)

Comment:

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

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

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other USC Annenberg Center for Health Journalism (Name)

USC, Disbursement Control, University Park (Address) Los Angeles (City) CA (State) 90089 (Zip Code)

Journalism center focused on health access, health, and place and safety net issues.

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

Los Angeles, CA (Location of Travel)

3/18/18 - 3/19/18 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

DusitD2 Hotel (Name of Lodging Facility)

$450.00 (Lodging Expenses) $_____ (Meal Expenses) $595.05 (Transportation Expenses) $_____ (Other Expenses) $1,045.05 (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.

Reimburse travel to speak at 2018 California Fellowship journalist training institute regarding efforts to preserve gains made under the ACA and the Medicaid expansion, directly related to CC's functions to operate health ins. exchange and improve access to quality, affordable health care.

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

Last Name	First Name	Position/Title	Department/Division
Lee	Peter	Executive Director	Executive

4. Verification

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

_____ (Signature) Karen Johnson (Print Name) Chief Deputy Exec. Director (Title) 9/13/18 (month, day, year)

Comment:

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

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