

Payment to Agency Report

A Public Document

1. Agency Name

_____		_____	_____

_____	_____	_____ (month, day, year)	

_____ Last Name First Name
 1438 Webster Street, Suite 400 Oakland CA 94612
 Address City State Zip Code

A non-profit 501(c)(4) philanthropic organization dedicated to health care and public health issues in California
 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:
 N/A
 Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment N/A
 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: 9/15/2016 \$ 100,000.00
 Dates (month, day, year) Total Expenses

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.
 These grant funds support expenses associated with maintaining a medical price and quality transparency website, California HealthCare Compare.

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

None
 Last Name First Name Position/Title Department/Division
 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: Janice M Rocco Janice Rocco Deputy Commissioner 04/26/17
 Print Name Title (month, day, year)

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

Payment to Agency Report

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PAYMENT TO AGENCY REPORT

1. Agency Name
California Department of Insurance
Division, Department, or Region (if applicable)
Street Address
300 Capitol Mall, Suite 1700
Area Code/Phone Number
916-492-3500
Email
Janice.Rocco@insurance.ca.gov
Agency Contact (name and title)
Janice Rocco, Deputy Commissioner, Health Policy and Reform
Date Stamp
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: 04/26/17 (month, day, year)

2. Donor Name and Address

Individual [] Other [x] California Endowment
Last Name First Name Name
1000 N. Alameda Street Los Angeles CA 90012
Address City State Zip Code

A California non-profit public benefit corporation dedicated to health care and public health issues in California

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:

N/A
Name Amount Name Amount

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment
N/A
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:
1/13/2017 \$ 200,000.00
Dates (month, day, year) Total Expenses

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

These grant funds support expenses associated with maintaining a medical price and quality transparency website, California Healthcare Compare.

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

None
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.

Janice M. Rocco Janice Rocco Deputy Commissioner 04/26/17
Signature Print Name Title (month, day, year)

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