

Gift to Agency Report

A Public Document

GIFT TO AGENCY REPORT

1. Agency Name		Date Stamp	California Form 801 For Official Use Only
California Department of Health Care services			
Division, Department, or Region (if applicable) Pharmacy Benefits Division			
Street Address 1501 Capitol Avenue, Sacramento, CA 95818			
Area Code/Phone Number (916) 440-7418	E-mail brian.hansen@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: <u>7/08/09</u> <small>(month, day, year)</small>	
Agency Contact (name and title) Brian Hansen, Special Assistant to the Director (Acting)			

2. Donor Name and Address

Individual _____ Other Southern Assoc. of Medicaid Pharm. Admin.

Last Name: _____ First Name: _____ Name: _____
 Address: 313 Old World Drive City: Columbia State: SC Zip Code: 29212
 Address City State Zip Code

Non-profit with primary purpose of convening meetings of state medicaid pharmacy administrators
 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) solicited or received by the donor for this gift:

_____	\$ _____	_____	\$ _____
Name	Amount	Name	Amount

3. Payment Information

Date and Amount of Payment (other than travel) _____ \$ 0.00
(month, day, year) (Round to whole dollars)

Travel Payment Information (Round to whole dollars) Location of Travel _____

<u>June 13-17, 2009</u>	\$ <u>449.40</u>	\$ <u>357.00</u>	\$ <u>280.00</u>	\$ <u>30.00</u>	\$ <u>1116.40</u>
Date(s) of Travel	Transportation Expenses	Lodging Expenses	Meal Expenses	Other Expenses	Total Expenses

Provide a specific description of the nature and use of the payment for official agency business:

Multiple Medicaid pharmacy issues at the national and state level were discussed. Several groups attended, including the Federal Centers for Medicare and Medicaid Services, First Data Bank (the Department of Health Care Services' data repository), and pharmacy industry representatives.

Identify the officials for whom the payment was used:

<u>Furukawa</u>	<u>Diane</u>	<u>Pharm. Prog. Consultant</u>	<u>Pharmacy Benefits Div.</u>
Last Name	First Name	Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Title	Department/Division

4. Verification

I have determined that it is in the interests of the agency to accept this gift and use it for the official agency business described above.

Brian L. Hansen Brian L. Hansen Special Assist. to the Director 7/8/09
 Signature of Agency Head or Designee Print Name Title (month, day, year)

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