Payment to Agency Re	eport	A Public D	ocument		1	PAYMENT TO A	SENCY REPORT
1. Agency Name				Date Sta	ama .	Californi	
Mental Health Services Ove	ersight and Accoun	tability Commiss	ion	PAACTIC	PULITIC IS COM	Form	OUI
Division, Department, or Region (if applicable)			ľ		Fui Onicia	al Use Only	
				24 JUL	30 PM	3: 16	
Street Address							
1812 9th Street, Sacrament	o, CA 95811						
Area Code/Phone Number	Email			□ A			>
916-500-0577	mhsoac@mhsoa	c.ca.gov		Amename	ent (explain ir	comment section	π)
Agency Contact (name and title)				Date of Origin	al Filing: _	/	
Norma Pate, Deputy Directo	or, Administrative a	and Performance	Managemei			(month, day, y	rear)
2. Donor Name and Addre	SS						
			Othor	Kooth USA L	LC		
☐ Individual ————————————————————————————————————	First	Name	Other		N	ame	
1828 Walnut St, 3rd floor		Kansas City			MO	64108	
Address		City			State	Zip Code	
Digital Innovator for Behavior	oral HealthCare pa	irtnering with gov	't. & other he	ealth entities to	o improve	mental hea	ilth issues.
If "Other" is marked, describe the entity's	s business activity (if busir	ess) or its nature and in	terests.				
If applicable, id	dentify the name of e	ach source and the	e amount(s) re	eceived by the o	donor for th	nis pavment:	
Name	\$	Amount		Name		\$	Amount
3. Payment Information (C	omplete Section	ns 3 1 (a or h)	3 2 3 3)				
	London, Engla	• • • • • • • • • • • • • • • • • • • •	3.2, 3.3)		June 23	-29, 2024	
3.1 (a) Travel Payment		Location of Travel		-0:			year)
United Airlines/Lyft/UK Tube	e - 5:			— 0.11	Hilton &	ates (month, day,	SPÓ
Transportation Provider	Rail	Air B Check Applicable B		Other	MOTEL FAI	nano (over ime of Lodging F	n Glaraer acility
2,366.48	227 00	2.638.31	0,000			5,231.79	
\$ Lodging Expenses \$.	Meal Expenses	\$	\$_ penses	Other Expenses	-	Total Exper	nses
3.1 (b) Payment(s) not rel	ated to travel:			\$			
o.r (b) r dymondo, not ron			Dates (month, d			Total Expense	es
3.2. Payment Description.	Provide a speci	fic description o	of the payme	ent and its ag	jency pui	rpose and ι	ise.
	•	•		_		•	
The Commission has be England to speak on its		•					
are reimbursements to		•				-	
	16	•	•		апорон	to/ffoffi til	c airport.
3.3. Identify the officials w	tho used the payi	ment in Section	3.1 (See instruc	ctions)			
Madrigal-Weiss	Mara		Commission		_ MHS		
Last Name	First Nam	e	Posi	tion/Title 🐇		Department/D	ivision
Last Name	First Nan	ne	Posi	tion/Title		Department/E	Division
. Varification							
. Verification	.60			u. EDDO	1-4:		
I authorized the acceptance						-/	2-1
Johercung	Toby E	Mng	<u> </u>	outive Dira	ector		13/24
8 gnature		Print Name		Title		(moi	nth, day, year)
Comment:							

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

Payment to Agency R	eport	A Public Doo	ument		F	PAYMENT TO AGENCY REPOR
1. Agency Name				Date Sta	imp	California Q 1
Mental Health Services Over	ersight and Accoun	tability Commission	e	PAINTS CO	หู้เรียง	Form OU
Division, Department, or Reg	gion (if applicable)		11.13	12 1 1 22 10 m m m m m m m m m m m m m m m m m m		For Official Use Only
			24	JUL 30 P	M 3: 16	
Street Address						
1812 9th Street, Sacrament	to, CA 95811					
Area Code/Phone Number	Email				44 1	
916-500-0577	mhsoac@mhsoac	c.ca.gov		Amename	comment section)	
Agency Contact (name and title)				Date of Origin	al Filing: _	
Norma Pate, Deputy Directo	or, Administrative a	nd Performance Ma	nagemei			(month, day, year)
Donor Name and Addre						
. Donor Name and Addre	.33			Kooth USA L	LC	
☐ Individual ————————————————————————————————————	First	Name	Other			ame
1828 Walnut St, 3rd floor		Kansas City		MO		64108
Address		City			State	Zip Code
Digital Innovator for Behavi	ioral HealthCare pa	rtnering with gov't.	& other he	ealth entities to	o improve	mental health issues
If "Other" is marked, describe the entity	's business activity (if busin	ess) or its nature and intere	sts.			
If applicable i	identify the name of a	ach source and the a	mount(c) re	accived by the	donor for th	oic navment:
ii applicable, i	dentity the name of e	ach source and the ar	nount(s) re	ceived by the t	201101 101 11	iis payment.
Name	\$	Amount		Name		\$
			2 0 0)	Name		Anount
. Payment Information (C	•		2, 3.3)		luma 22	20, 2024
3.1 (a) Travel Payment	London, Engla			=::		-29, 2024
Note that I Adults and II II Took a IT a		_ocation of Travel				ates (month, day, year)
United Airlines/UK Tube/Ta	Rail	Air Bus	☐ Auto	Other		nano, Covent Garden
Transportation Provider	007.00	Check Applicable Boxes	5		INC	
\$ 2,050.49	227.00	\$ 3,331.18	_ \$_	011	_	\$ 5,608.67 Total Expenses
Lodging Expenses	Meal Expenses	Transportation Expen	ses	Other Expenses		Iotal Expenses
3.1 (b) Payment(s) not re	lated to travel:	D	ates (month, d	(av vear)		Total Expenses
0.0 D	D		,			•
3.2. Payment Description	. Provide a specii	ric description of t	ne payme	ent and its ag	jency pui	rpose and use.
The Commission has I	been invited to s	erve on a panel	for the E	Brain Capita	al UK Su	ımmit in London,
England to speak on it		•				·
are reimbursements to	cover flights, he	otel stay and trav	vel expe	nses, i.e. tr	ansport	to/from the airport
3.3. Identify the officials v	who used the payr	ment in Section 3.1	See instru	ctions)		
Ewing	Toby	Ex	ecutive D	irector	MHS	SOAC
Last Name	First Nam			tion/Title	_	Department/Division
Last Name	First Nam	ne	Posi	tion/Title		Department/Division
. Verification						
I authorized the acceptance	e of the reported par	vment(s) as in comi	oliance wi	th FPPC reau	lations.	E8
1/ 0	Tala E	(NILVA)				r 7/22/21
Signature	ny longe	Print Name		Xecutive Title	VIIEUL	(month. dav. year)
Signal	The state of the s	· · · · · · · · · · · · · · · · · · ·		0		
Commont:						

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Payment to Agency R	eport	A Public Docu	ment		PAYMENT TO AGENCY REP
1. Agency Name				Date Stamp	California On
Mental Health Services Over	ersight and Account	ability Commission _,	ARCTI	EFS COMMISSIO	Form OU
Division, Department, or Reg	jion (if applicable)			A fine and	For Official Use Only
			24 J\l	_30 PM 3:16	}
Street Address					
1812 9th Street, Sacramen	to, CA 95811				
Area Code/Phone Number	Email		-		
916-500-0577	mhsoac@mhsoac	c.ca.gov		Amendment (exp	plain in comment section)
Agency Contact (name and title)				Date of Original Filir	
Norma Pate, Deputy Direct	or, Administrative ar	nd Performance Mana	agemei		(month, day, year)
2. Donor Name and Addre					
2. Donor Name and Addre	:55			Kooth USA LLC	
☐ Individual	First N	Jamo	Other -	ROOM OSA LLC	Name
1828 Walnut St, 3rd floor	Filsti	Kansas City		МО	64108
Address		City		State	Zip Code
Digital Innovator for Behavi	ioral HealthCare par	tnering with gov't. & c	other hea	alth entities to imp	rove mental health issue
If "Other" is marked, describe the entity	<u>_</u>				
in outer to marked, decorbe are only	o submission double, (ii submission)	os, or no nature and more con-	•		
If applicable, i	dentify the name of ea	ach source and the amo	ount(s) red	ceived by the donor	for this payment:
	\$				\$
Name	Ψ	Amount		Name	Amount
3. Payment Information (C	omplete Section	s 3.1 (a or b), 3.2,	3.3)		
3.1 (a) Travel Payment	London, Engla	•	,	June	e 23-29, 2024
3.1 (a) Traverr ayment		ocation of Travel		9	Dates (month, day, year)
United Airlines/Uber	E D.:	MAIN INDIA	- A	The The	Hoxton, Holton
Transportation Provider	Rail	Air Bus Check Applicable Boxes	☐ Auto	Other	Name of Lodging Facility
£ 2,639.26	227.00	1,628.22			4,494.48
\$ Lodging Expenses	Meal Expenses	Transportation Expenses	\$_	Other Expenses	STotal Expenses
3.1 (b) Payment(s) not re	lated to travel:	, ,		\$	
o. r (b) r ayment(s) not re	ated to traver.	Dates	s (month, day	у, year) — — — — — — — — — — — — — — — — — — —	Total Expenses
3.2. Payment Description	Provide a specifi	ic description of the	navmer	nt and its agency	r purpose and use
	•	•			•
The Commission has b		•			
England to speak on it		•			<u>-</u>
are reimbursements to	cover flights, no	itel stay and trave	ı expen	ises, i.e. transp	ort to/from the airpor
3.3. Identify the officials v	who used the paym	nent in Section 3.1 (See instructi	ions)	
Brown	Bill	Com	missione	er N	MHSOAC
Last Name	First Name	· · · · · · · · · · · · · · · · · · ·	Positio	on/Title	Department/Division
*					
1					
Last Name	First Name	9	Position	on/Title	Department/Division
l. Verification			•		
I authorized the acceptance	of the reported nav	ment(s) as in complia	ance with	FPPC regulation	is.
1 / C	T.L.	A OLO	HAV A		= /= /
Joby Ewing	1 lopy b	VVIV)9	- Will	WITIVE DIVE	octor //23/2
Signature		r mat Nasure		ride	(month, day, yea
Comment:					
(Use this space or an attachment f	or any additional informa	ation)			EPPC Form 801 / Jax

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