Payment to Agency Re	eport	A Public Doc	ument		t	PAYMENT TO AGENCY REPOR
1. Agency Name				Date Sta	amp	California 801
Department of Health (Care Services					Form OUT
Division, Department, or Reg	ion (if applicable)					For Official Use Only
Administration Division	, Human Resou	rces Branch				
P.O. Box 997411, MS	1300					
Area Code/Phone Number	IEmail					
(916) 552-8270	0	aat@dhaa aa ga		Amendme	e nt (explain ir	n comment section)
Agency Contact (name and title)		est@dhcs.ca.go	V	Date of Origin	al Filing: _	
Conflict of Interest Filin						(month, day, year)
2. Donor Name and Addres	ss					
🗍 Individual		Г	Other	National Ass	sociation o	of Medicaid Directors
Last Name	First f	lame				ame
444 Capitol Avenue, Suite 5	524	Washington			DC	20001
		City			State	Zip Code
NAMD's sole function is to r				states, territ	ories & th	e District of Columbia.
If "Other" is marked, describe the entity's	s business activity (if busine	ss) or its nature and interes	is,			
If applicable, ic	dentify the name of ea	ach source and the an	nount(s) re	eceived by the	donor for tl	nis payment:
	¢					¢
Name	φ	Amount		Name		Amount
3. Payment Information (C	omplete Section	s 3.1 (a or b), 3.2	, 3.3)			
3.1 (a) Travel Payment	Madison, Wisc	onsin			June 10	-13, 2018
	L	ocation of Travel		-	D	ates (month, day, year)
United Airlines	🛛 Rail	🖂 Air 🔲 Bus	Auto	o □ Other	The Edg	jewater
Transportation Provider		Check Applicable Boxes	-		Na	ame of Lodging Facility
\$ 585.60 \$	64.00	\$ 1,318.57	\$	15.00		\$ ^{1,397.57}
Lodging Expenses	Meal Expenses	Transportation Expens	es .	Other Expenses	3	Total Expenses
3.1 (b) Payment(s) not rela	ated to travel:				6	
			es (month, c	0.00		Total Expenses
3.2. Payment Description.	Provide a specif	c description of th	e payme	ent and its ag	gency pu	rpose and use.
To attend the National	Association of N	ledicaid Director	's (NAN	ID) Spring	Confere	nce from June
10-12, 2018 and NAME	D's Scorecard M	eeting on June 1	3, 2018	3		
3.3. Identify the officials w	who used the payn	nent in Section 3.1	(See instru	ctions)		
Brooks	Sarah		puty Dire		Hea	Ith Care Delivery
Last Name	First Name			ition/Title		Department/Division
Last Name	First Nom		Dee	iai a a / Tiai a		Decederat/Division
Last Name	First Nam	5	Pos	ition/Title		Department/Division
20 30 may 13						
4 Verification						

Original Signad Pyr	reported payment(s) as in compliance with FPPC regulations.				
Original Signed By:	Erika Sperbeck	Chief Deputy Director			
	Print Name	Title	2.53		

(month, day, year)

Comment:

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

Payment to Agency Rep	port	A Public D	ocument		PAYMENT TO AGENCY REPORT
1. Agency Name				Date Stamp	California 801
Department of Health Ca					Form OUT For Official Use Only
Division, Department, or Regio	n (if applicable)				For Official Use Only
Administration Division, Street Address	Human Resou	rces Branch			
P.O. Box 997411, MS 1	300				
Area Code/Phone Number	Email			Amendment (ex	plain in comment section)
(916) 552-8270	ConflictofInte	rest@dhcs.ca	.gov		Santa Anna anna 1993 (Santa Anna Anna Anna Anna Anna Anna Anna
Agency Contact (name and title)				Date of Original Filir	ng:(month, day, year)
Conflict of Interest Filing					
2. Donor Name and Address	S				
🗇 Individual	-		Other	National Associati	ion of Medicaid Directors
Last Name 444 Capitol Avenue, Suite 52		_{Name} Washington		DC	Name 20001
Address		City		State	Zip Code
NAMD's sole function is to re	present & suppor	t the Medicaid D	irectors in 56	o states, territories	& the District of Columbia.
If "Other" is marked, describe the entity's b	ousiness activity (if busin	ess) or its nature and in	terests.		
If applicable, ide	ntify the name of a	ach source and the	e amount(s) ro	eceived by the donor	for this navment
	antity the name of e	ach source and th	e amount(s) R	scelved by the donor	for this payment.
Name	\$	Amount		Name	\$ Amount
3. Payment Information (Co	mplete Section	s 3 1 (a or b)	3 2 3 3)		E SHAL VLASER
3.1 (a) Travel Payment	Madison, Wise		0.2, 0.0)	June	e 10-12, 2018
5.1 (a) Haver Fayment		ocation of Travel		-	Dates (month, day, year)
United Airlines	🗆 Rail	∏Air ∏B	us 🗌 Auto	D □ Other The	Edgewater
Transportation Provider		Check Applicable B			Name of Lodging Facility
\$ ^{390.40} \$ ²	3.00	\$ 636.42	\$	15.00	\$
Lodging Expenses	Meal Expenses	Transportation Ex	penses	Other Expenses	Total Expenses
3.1 (b) Payment(s) not relat	ed to travel:		Dates (month, o	\$	Total Expenses
			•		Second P C 201 December 200
3.2. Payment Description.					 I trend L. For the star star sectors where a sector of the sector of the
To attend the National A	ssociation of N	Medicaid Direc	ctor's (NAN	ID) Spring Conf	ference from June
10-12, 2018.					
×					
3.3. Identify the officials whe	io used the payr	nent in Section	3.1 (See instru		
Harrington	Lindy		Deputy Dire		Health Care Financing
Last Name	First Nam	e	Posi	ition/Title	Department/Division
					L
Last Name	First Nam	ne	Pos	ition/Title	Department/Division
A Varification					
	reported pay	yment(s) as in co	ompliance wi	th FPPC regulation	IS.
Original Cignad Dyg					
Original Signed By:	Erika Sperb	beck	Chief	Deputy Director	8.118

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Comment:

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

Payment to Agency Re	eport	A Public D	ocument		PAYMENT TO AGENCY REPORT
1. Agency Name				Date Stam	California 801
Department of Health C	Care Services				Form OUT
Division, Department, or Regi	ion (if applicable)				For Official Use Only
Administration Division Street Address	, Human Resou	rces Branch			
P.O. Box 997411, MS	1300				
Area Code/Phone Number	Email				
(916) 552-8270	ConflictofInte	rest@dhcs.ca	.gov		t (explain in comment section)
Agency Contact (name and title)				Date of Original	Filing:(month, day, year)
Conflict of Interest Filin	g Officer				(month, day, year)
2. Donor Name and Addres	ŝs				
🗌 Individual			☑ Other	National Quali	ty Forum
Last Name		Name	M Other		Name
1030 15th Street, NW Suite	800	Washington			D.C. 20005
Address	6 1 11	City			tate Zip Code
I O IMProve health & perform				n & use of evide	ence to inform policy & practice.
Name	\$	Amount		Name	nor for this payment: \$
3. Payment Information (Co	omplete Section	ns 3.1 (a or b).	3.2.3.3)		
3.1 (a) Travel Payment	Washington, D		,,	C	05/08/2018 - 05/10/2018
		ocation of Travel			Dates (month, day, year)
United Airlines	🖂 Rail	🖸 Air 📋 Bu	us 🗌 Auto	o ∏ Other ^H	lotel Rouge
Transportation Provider		Check Applicable Bo			Name of Lodging Facility
€ 596.68 €	31.96	€ 665.26	¢		€ 1,293.90
Φ-Lodging Expenses	Meal Expenses	Transportation Exp	penses .	Other Expenses	Φ
3.1 (b) Payment(s) not rela	ated to travel:			\$	×
			Dates (month, d	ay, year)	Total Expenses
3.2. Payment Description.	Provide a specif	fic description o	f the payme	ent and its age	ncy purpose and use.
To attend and participa Washington, D.C.	te at the Nation	al Quality For	um's Medio	caid Adult In-	person Meeting in
3.3. Identify the officials w	ho used the payr	ment in Section	3.1 (See instruc	ctions)	
Logan	Julia		Public Healt	h Medical Offic	DHCS/OMD
Last Name	First Nam	ie	Posi	tion/Title	Department/Division
Last Name	First Nam		Posi	tion/Title	Department/Division

1 Verification			
	reported payment(s) as in c	ompliance with FPPC regulations.	
Original Signed By:	Erika Sperbeck	Chief Deputy Director	8.1.18
	Print Name	Title	(month, day, year

Comment:

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Payment to Agency Rep	ort A Public Doci	iment	PAYMENT TO AGENCY REPOR
1. Agency Name		Date Stamp	California 801
Department of Health Ca	re Services		Form OU
Division, Department, or Region			For Official Use Only
Administration Division, H	luman Resources Branch		
Street Address			
P.O. Box 997411, MS 13	300		
Area Code/Phone Number E	mail	Amendment (e	explain in comment section)
(916) 552-8270	ConflictofInterest@dhcs.ca.gov	v —	
Agency Contact (name and		Date of Original Fi	(month, day, year)
title) Conflict of Interest Filing Officer			p 6 389 77
2. Donor Name and Address			
🗌 Individual		Other Academy Health	
Last Name	First Name		Name
1666 K St. NW, Suite 1100	Washington _{City}	DC Stat	
	sional home for health services resea		
	isiness activity (if business) or its nature and interest		
If applicable, ider	ntify the name of each source and the am	ount(s) received by the donc	or for this payment:
	\$		
Name	Amount	Name	Amount
3. Payment Information (Cor	nplete Sections 3.1 (a or b), 3.2,	· · ·	
3.1 (a) Travel Payment	Washington, DC	Ma	ay 2-4, 2018
	Location of Travel		Dates (month, day, year)
American Airlines	🗌 Rail 🛛 Air 🔄 Bus	Auto Other Th	e Darcy
Transportation Provider	Check Applicable Boxes	70 70	Name of Lodging Facility
\$\$\$\$	\$ 570.10	\$	\$ Total Expenses
	Meal Expenses Transportation Expense	s Other Expenses	Total Expenses
3.1 (b) Payment(s) not relate		es (month, day, year)	Total Expenses
3.2 Payment Description	Provide a specific description of the		
	Construction of the design of the product of the second states		
	ledical Directors Network Acad	lemyHealth Spring W	orkshop in Washington,
D.C.			
3.3. Identify the officials whe	o used the payment in Section 3.1	(See instructions)	
Logan	Julia Put	lic Health Medical Offic	DHCS/OMD
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division
4. Verification			
4. verification			
Original Cines d Dur	reported payment(s) as in compl		-
Original Signed By:	Erika Sperbeck	Chief Deputy Director	<u> </u>
	Print Name	Title	(month, day, year)
Comment:			

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

FPPC Form 801 (Jan/14) advice@fppc.ca.gov



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Payment to Agency Re	eport A Public I)ocument		PAYMENT TO AGENCY REPORT
1. Agency Name			Date Stamp	California 801
Department of Health C	Care Services			Form OUT
Division, Department, or Regi	ion (if applicable)			For Official Use Only
Administration Division	, Human Resources Branch			
P.O. Box 997411, MS	1300			
Area Code/Phone Number	Email		Amendment (explain i	n comment section)
(916) 552-8270	ConflictofInterest@dhcs.ca	a.gov		
Agency Contact (name and title)			Date of Original Filing:	(month, day, year)
Conflict of Interest Filin	g Officer			(
2. Donor Name and Addres	SS		•	
□ Individual		. 🖸 Other	NASADAD	
Last Name	First Name			lame
1919 Pennsylvania Avenue	NW, Suite M-250 Washington		DC	20006
Address	City		State	Zip Code
NASADAD supports the dev	velopment of effective substance u	ise disorder p	programs and policy.	
If "Other" is marked, describe the entity's	business activity (if business) or its nature and i	nterests.		
If applicable, ic	lentify the name of each source and th	ne amount(s) r	eceived by the donor for t	his payment:
Name	\$ Amount		Name	\$Amount
3. Payment Information (C	omplete Sections 3.1 (a or b) Washington D.C.	, 3.2, 3.3)	May 21	-24, 2018

3.1 (a) Travel Payment	Washington D.	C.		May 21-24, 2018	
., .	Lo	ocation of Travel		Dates (month, day, year)	-
American Airlines,	T Rail	🖂 Air 🗖 Bus Г]Auto ☐ Other	Marriott Bethesda, MD	
Transportation Provider		Check Applicable Boxes		Name of Lodging Facility	-M
1,012.00	2 41.50	958.41	¢	\$ 2,711.91	
Lodging Expenses	Meal Expenses	Transportation Expenses	Olher Expenses	Total Expenses	
3.1 (b) Payment(s) not re	elated to travel:		\$	3.	
		Dates (n	nonth, day, year)	Total Expenses	-

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

Denise Galvez, as the National Prevention Network and Women's Services Network representative to California, attended the annual business meeting of the National Association of State Alcohol and Drug Abuse Directors. NASADAD provided travel stipends to meeting attendees.

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

Galvez	Denise	Section Chief	DHCS, SUD-PPFD
Last Name	First Name	Position/Title	Department/Division
Last Name	First Name	Position/Title	Department/Division
Verification			lations
	reported payment(s) as in	n compliance with FPPC regu	liations.
Driginal Signed By:	Erika Sperbeck	Chief Deputy Dire	ctor 8, 6, 8
	Print Name	Title	(month, day, year)

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