ayment to Agency Repo	rt AP	ublic Docun	ient		PAYMENT TO AGENCY REPOR
Agency Name			Date Sta	ımp	California 201
Department of Health Care	Services				Form OU
Division, Department, or Region (i	i applicable)				For Official Use Only
Administration Division, Hu Street Address	man Resources I	Branch			
P.O. Box 997411, MS 130	0				
Area Code/Phone Number Ema	ail	K41-00 6-000-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-11-00-1	[] Amendme	nt (evolain	n comment section)
(916) 552-8270 C	onflictofInterest@	dhcs.ca.gov	Amendine	III (CAPIGIII	in comment section;
Agency Contact (name and title)		· · · · · · · · · · · · · · · · · · ·	Date of Origin	al Filing: .	(month, day, year)
Conflict of Interest Filing O	fficer		а		(
Donor Name and Address	**************************************	****	72		
☐ Individual	-		ther Mational Ass		of Medicaid Directors
Last Name	First Name			DC	lame 20001
444 North Capitol St., NW, Suite	City	shington		State	Zip Code
NAMD's sole function is to repre		Medicald Direct	or's in 50 states to		
If "Other" is marked, describe the entity's busin			or sim ou states, ter	THORES C	the District of Columbi
To dies is marked, describe the entity's busine	Bas activity (ii business) of its	nature and interests.			
If applicable, identify	y the name of each sou	irce and the amoui	nt(s) received by the	donor for	his payment:
	\$				\$
Name	Amount		Name		Amount
Payment Information (Comp	lete Sections 3.1	(a or b), 3.2, 3	3)		
3.1 (a) Travel Payment	Washington, DC	An agusta, sa cara i	in the second of	11/10/1	9-11/13/19
	Location o	f Travel			Dates (month, day, year)
United	Rail 🛛 A	ir □Bus □] Auto		gton Hilton
Transportation Provider		Applicable Boxes		N	ame of Lodging Facility
\$ 893.16	00 \$ 6	006.61	\$ 160.41		\$_1,801.18
Lodging Expenses Mea	Expenses Train	nsportation Expenses	Other Expenses	87	Total Expenses
3.1 (b) Payment(s) not related	to travel:	4	4	<u> </u>	
			——————————————————————————————————————		
		10	nonth, day, year)		Total Expenses
3.2. Payment Description. Pro	vide a specific des	10		јепсу рі	60 FL Total 2008 (100 Feb.)
3.2. Payment Description. Pro To attend the NAMD confe		cription of the p		јепсу рі	60 FL Total 2008 (100 Feb.)
		cription of the p		јепсу рі	60 FL Total 2008 (100 Feb.)
		cription of the p		јепсу рі	00 FL F188, 0128 • VOSESO • 500
	rence in Washing	cription of the p	ayment and its aç	јепсу рі	60 FL Total 2008 (100 Feb.)
To attend the NAMD confe	rence in Washing	cription of the posterion DC.	ayment and its aç		irpose and use.
To attend the NAMD confers 3.3. Identify the officials who uses the second seco	rence in Washing	cription of the posterion DC.	ayment and its aç		60 FL Total 2008 (100 Feb.)
To attend the NAMD confers 3.3. Identify the officials who and continued the confers of the con	rence in Washing used the payment in Mari	cription of the posterion DC.	ayment and its ag		ector's Office
To attend the NAMD confers 3.3. Identify the officials who used to the control of the confers o	rence in Washing used the payment in Mari First Name	cription of the posterion DC.	e instructions) Deputy Director Position/Title		ector's Office Department/Division
To attend the NAMD confers 3.3. Identify the officials who and continued the confers of the con	rence in Washing used the payment in Mari	cription of the posterion DC.	ayment and its ag		ector's Office
3.3. Identify the officials who cantwell Last Name Last Name	rence in Washing used the payment in Mari First Name	cription of the posterion DC.	e instructions) Deputy Director Position/Title		ector's Office Department/Division
To attend the NAMD confers 3.3. Identify the officials who used to the control of the confers o	rence in Washing used the payment in Mari First Name	cription of the posterion DC.	e instructions) Deputy Director Position/Title		ector's Office Department/Division
3.3. Identify the officials who cantwell Last Name Last Name	rence in Washing used the payment in Mari First Name	ton DC. Section 3.1 (Se	e instructions) Deputy Director Position/Title	Dire	ector's Office Department/Division
3.3. Identify the officials who cantwell Last Name Last Name	rence in Washing used the payment in Mari First Name First Name	ton DC. Section 3.1 (Se	e instructions) Deputy Director Position/Title	Dire	ector's Office Department/Division
3.3. Identify the officials who cantwell Last Name Last Name	rence in Washing used the payment in Mari First Name First Name	cription of the particle of th	e instructions) Deputy Director Position/Title Position/Title ce with FPPC regu	Dire	ector's Office Department/Division Department/Division
3.3. Identify the officials who cantwell Last Name Last Name	rence in Washing used the payment in Mari First Name First Name reported payment(Erika Sperbeck	cription of the particle of th	e instructions) Deputy Director Position/Title Position/Title ce with FPPC regu	Dire	ector's Office Department/Division Department/Division

Payment to Agency Rep	ort A Public	Document		Р	AYMENT TO AGENCY REPORT
1. Agency Name			Date Sta		California 801
Department of Health Car			500	Form OU I	
Division, Department, or Region	N Ad S			e	For Official Use Only
Administration Division, H Street Address	uman Resources Branc	:h	17		20
P.O. Box 997411, MS 13	00				
Area Code/Phone Number En	nail		☐ Amendme	nt (explain in	comment section)
	ConflictofInterest@dhcs	.ca.gov			,
Agency Contact (name and title) Conflict of Interest Filing (Officer		Date of Origina	ai Filing:	(month, day, year)
2. Donor Name and Address	Jilicel	· ·			
			National Ass	ociation o	f Medicaid Directors
☐ Individual Last Name	First Name	Ø Other	***		me
444 North Capitol St., NW Suite		on		DC	20001
NAMD's sole function is to repr	City	said Directors in	50 states terr	State	Zip Code
If "Other" is marked, describe the entity's bus			ou states, ten	nones, a	Discrict of Columbia.
If applicable, ident	ify the name of each source and	d the amount(s) re	eceived by the d	lonor for th	is payment:
Name	\$		Name		\$
3. Payment Information (Com	nlete Sections 3.1 (a or	h) 3 2 3 3)			
3.1 (a) Travel Payment	Washington, DC	D), 0.2, 0.0)		11/10/19	- 11/13/19
(a) maron aymone	Location of Travel		-	Da	tes (month, day, year)
United	Rail 🛛 Air 🖒	Bus □ Auto	Other	Washing	ton Hilton
Transportation Provider	Check Applicat	ole Boxes		Na	me of Lodging Facility
\$ 893.16 Lodging Expenses \$ 128	3.00 \$725.74 eal Expenses Transportation		31.99	_	\$ \$
3.1 (b) Payment(s) not related		on Expenses	Other Expenses		Total Expenses
o. i (b) Payment(s) not related	a to traver.	Dates (month, o	iay, year)		Total Expenses
3.2. Payment Description. Pr	ovide a specific description	on of the payme	ent and its ag	ency pur	pose and use.
Payment was for attendar					
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		.3.0, _	
3.3. Identify the officials who	used the payment in Secti	ion 3.1 (See instru	ctions)		
Brooks	Sarah	Deputy Dire	ctor	Healt	h Care Delivery System
Last Name	First Name	Posi	tion/Title		Department/Division
9 7					
Last Name	First Name	Pos	ition/Title		Department/Division
4. Verification	* * * * * * * * * * * * * * * * * * *				
	ne reported payment(s) as in	n compliance wi	th FPPC regul	ations.	
	Erika Sperbeck	Chief	Deputy Direct	tor	11.25.19
,	Print Name		Title		(month, day, year)
Comment:					
(Use this space or an attachment for an	y additional information)		***************************************		FPPC Form 801 (Jan/14)

advice@fppc.ca.gov

Payment to Agency	Report A Pub	lic Document		PAYMENT TO AGENCY REPOR	
. Agency Name			Date Stamp	California On4	
Department of Healt	h Care Services		Form OU		
Division, Department, or I		**************************************		For Official Use Only	
Administration Divis	ion, Human Resources Bra				
Street Address			•		
P.O. Box 997411, M				×	
Area Code/Phone Number	er Email		Amendment (expla	ain in comment section)	
(916) 552-8270	ConflictofInterest@dh	cs.ca.gov	Date of Original Filing	••	
Agency Contact (name and			Date of Original Filing:(month, day, year)		
Conflict of Interest F					
Donor Name and Add	iress		Nintinnal Appoints	on of Madionid Diverture	
☐ Individual	First Name	Other	National Association	on of Medicaid Directors	
444 North Capitol St., N		gton	DC	20001	
Address	City		State	Zip Code	
NAMD's sole function is	to represent and support the Me	dicaid Director's in	50 states, territories	s & the District of Columb	
if "Other" is marked, describe the er	ntity's business activity (if business) or its natu	re and interests.	***************************************	the state of the s	
If applicabl	e, identify the name of each source	and the amount(s) re	eceived by the donor for	or this payment:	
			en e		
Name	Amount		Name	Amount	
3.1 (a) Travel Payment	Washington, DC Location of Trav	el	***************************************	0/19-11/13/19 Dates (month, day, year)	
United; Southwest	□ Rail ☑ Air	☐ Bus ☐ Auto	o	nington Hilton	
Transportation Provid	Опеск Арр	icable Boxes	20.00	Name of Lodging Facility	
\$ Lodging Expenses	\$ 164.00 \$ 619. Meal Expenses Transpor	45 Iation Expenses	20.00 Other Expenses	\$ Total Expenses	
3.1 (b) Payment(s) not			\$	3	
		Dates (month, o	day, year)	Total Expenses	
3.2. Payment Description	on. Provide a specific descrip	tion of the payme	ent and its agency	purpose and use.	
To attend the NAMD	conference in Washington	DC.			
	0				
3.3. Identify the official	s who used the payment in Se	ction 3.1 (See instru	ctions)		
Cooper	Jacey	Senior Advi	sor D	irector's Office	
Last Name	First Name	Pos	ition/Title	Department/Division	
Last Name	First Name	Pos	ition/Title	Department/Division	
		-		De partiriona de la companya de la c	
Verification	The second secon				
The state of the s	the reported payment(s) a	s in compliance wi	th EDDC regulations	it gets	
	Erika Sperbeck		f Deputy Director	110010	
	Print Name	Critei	Title	(month, day, year)	
			3.5555	(month, dul, year)	
Comment:	nt for any additional information)				

ayment to Agency Re	eport A Public	Document		PAYMENT TO AGENCY REPORT
. Agency Name			Date Stamp	California 201
Department of Health 0	Care Services		Form OUI	
Division, Department, or Reg				For Official Use Only
Administration Division Street Address	, Human Resources Branc	h		
P.O. Box 997411, MS	1300			
Area Code/Phone Number	Email		□ A a d a A /	
(916) 552-8270	ConflictofInterest@dhcs.	ca dov	Amendment (exp	lain in comment section)
Agency Contact (name and title)		ca.gov	Date of Original Filin	
Conflict of Interest Filin	g Officer			(month, day, year)
Donor Name and Addres	SS			
☐ Individual			CA Advocates for	Nursing Home Reform (CA
Last Name	First Name			Name
650 Harrison Street	San Franci	sco	CA	94107
Address	City		State	Zip Code
	rove the choices, care and quali		s long-term care co	nsumers.
If "Other" is marked, describe the entity's	s business activity (if business) or its nature ar	nd interests.		
If applicable, ic	dentify the name of each source and	the amount(s) re	eceived by the donor t	for this payment:
	Φ.		•	¢.
Name	Amount		Name	Amount
Payment Information (C	omplete Sections 3.1 (a or l	b), 3.2, 3.3)	-	
3.1 (a) Travel Payment	Monterey, CA		11/2	2-23/2019
on (a) navon aymone	Location of Travel		- .: 10	Dates (month, day, year)
	Rail Air C]Bus ☑ Auto	o □ Other ^{Mon}	terey Hotel & Spa
Transportation Provider		-	Other	Name of Lodging Facility
225.55	211.70			437.25
\$ \$. Lodging Expenses	Meal Expenses Transportation	n Expenses \$.	Other Expenses	Total Expenses
3.1 (b) Payment(s) not rela	ated to travel:		\$	
, , , , , , , , , , , , , , , , , , , ,		Dates (month, o	day, year)	Total Expenses
3.2. Payment Description.	Provide a specific descriptio	n of the payme	ent and its agency	purpose and use.
100 100 100 100 100 100 100 100 100 100				
To attenu and participa	te at the Elder Law Attorne	y contenence	elli ali ASK lile i	Expert session.
3.3. Identify the officials w	ho used the payment in Secti	on 3.1 (See instru	ctions)	
Jones	Dennis	Attorney		Office of Legal Services
Last Name	First Name	Pos	ition/Title	Department/Division
Last Name	First Name	Pos	ition/Title	Department/Division
Edot Humo	T HSC NAME	1 03	ALIOTI/ TIBE	Department Division
Verification				
	ne reported payment(s) as in	compliance wi	th FPPC regulation	S.
	Erika Sperbeck	Chi	of Deaths Die	(23.20)
Signature.	Print Name	CAM	Title)	(month, day, year)
			0.74	
Comment:				
(Use this space or an attachment for	or any additional information)			EPPC Form 801 / Jan/1

Payment to Agency Repor	t A Public Doc	ument	PAYMENT TO AGENCY REPORT
1. Agency Name		Date Sta	
Department of Health Care	Services		Form OU I For Official Use Only
Division, Department, or Region (if a			For Official Ose Offly
Administration Division, Hur Street Address	nan Resources Branch		
P.O. Box 997411, MS 1300			
Area Code/Phone Number Emai	II .	☐ Amendme	ent (explain in comment section)
	onflictofInterest@dhcs.ca.go	v _	2 0
Agency Contact (name and title)		Date of Origina	(month, day, year)
Conflict of Interest Filing Of	icer		
2. Donor Name and Address		Ni-PI A	
☐ Individual	First Name	Other Mational Ass	ociation of Medicaid Directors Name
444 North Capitol St., NW, Suite			DC 20001
Address	City		State Zip Code
NAMD's sole function is to repres	ent and support the Medicaid Dir	ector's in 50 states, ter	ritories & the District of Columbia
If "Other" is marked, describe the entity's busine	ss activity (if business) or its nature and interes	ts.	Ÿ
If applicable identify	the name of each source and the am	nount(s) received by the o	donor for this payment:
in applicable, identity	and realise of odding odding and and and		•
Name	\$	Name	Amount
3. Payment Information (Comp	lete Sections 3.1 (a or b), 3.2	, 3.3)	
	Vashington, DC		11/10/19-11/13/19
	Location of Travel		Dates (month, day, year)
United; Southwest	□ Rail ☑ Air □ Bus	☐ Auto ☐ Other	Washington Hilton
Transportation Provider	Check Applicable Boxes		Name of Lodging Facility
\$\frac{893.16}{\text{Lodging Expenses}} \text{\$\frac{164.0}{Meal}}	00 Expenses \$618.05 Transportation Expens	\$20.00 Other Expenses	\$\frac{1,695.21}{Total Expenses}
Loughing Experience		es Other Expenses	entervision de company
3.1 (b) Payment(s) not related to		tes (month, day, year)	Total Expenses
3.2. Payment Description. Pro-	vide a specific description of th	e payment and its ag	ency purpose and use.
To attend the NAMD confer	ence in washington bc.		
3.3. Identify the officials who u	sed the navment in Section 3.1	(See instructions)	
•		nior Advisor	Director's Office
Cooper Last Name	Jacey Se	Position/Title	Department/Division
Last Name	ristrano		
Last Name	First Name	Position/Title	Department/Division
4. Verification			
;he	e reported payment(s) as in comp	liance with FPPC regu	/
	Erika Sperbeck	Chief Deputy Direc	ctor /. 23. 20
	Print Name	Title	(month, day, year)
Comment:			
(Use this space or an attachment for any	additional information)		FPPC Form 801 (Jan/14

Payment to Agency Rep	ort A Public	Document		PAYMENT TO AGENCY REPORT	
1. Agency Name			Date Stamp	California 201	
Department of Health Car	re Services			Form OUI	
Division, Department, or Region	(if applicable)		For Official Use Only		
Administration Division, H	luman Resources Branc	h			
PROPERTY OF THE PROPERTY OF TH	00				
P.O. Box 997411, MS 13 Area Code/Phone Number IEr	nail		*		
(0.40) ====	 ConflictofInterest@dhcs.	00 gov	Amendment (explain in comment section)		
Agency Contact (name and title)	zonnicionnieresi@uncs.	.ca.gov	Date of Original Filing		
Conflict of Interest Filing	Officer			(month, day, year)	
2. Donor Name and Address					
☐ Individual		☑ Other	California Primary	Care Association	
Last Name	First Name	-		Name	
1380 Harbor Island Drive	San Diego	<u></u>	CA	92101 Zip Code	
CPCA leads in community clini		orks through ad		Lip Godd	
If "Other" is marked, describe the entity's bus			Trocacy.		
N Mary Park I Color	Cf. II.	1.11		Constitution and Constitution of	
If applicable, iden	tify the name of each source and	the amount(s) re	eceived by the donor f	or this payment:	
Name	\$	-	Name	\$	
3. Payment Information (Com	nlete Sections 3.1 (a or	h) 3 2 3 3)			
3.1 (a) Travel Payment	San Diego, CA	5), 5.2, 5.5)	10/18	3/19-10/18/19	
o. r (a) maver r ayment	Location of Travel		_	Dates (month, day, year)	
Southwest	Rail 🗸 Air 🗆]Bus □ Auto	o □ Other N/A		
Transportation Provider	Check Applicab		0 <u> </u>	Name of Lodging Facility	
\$\$	\$	\$.		\$	
	leal Expenses Transportatio	n Expenses	Other Expenses	Total Expenses	
3.1 (b) Payment(s) not relate	d to travel:	Dates (month, o	\$ 150.	Total Expenses	
3.2. Payment Description. P	rovida a enacific descriptio	8			
CPCA has agreed to reim to lead and position comm					
and services. Dr. Mark at					
3.3. Identify the officials who	*		• •		
Mark	Karen	Medical Dir		Office of the Medical Directo	
Last Name	First Name	17-18-18-18-18-18-18-18-18-18-18-18-18-18-	ition/Title	Department/Division	
	,			2 Sparanona 2 Wision	
		-			
Last Name	First Name	Pos	sition/Title	Department/Division	
A 3.7. (8)			***************************************	The state of the s	
4. Verification	9				
	the reported payment(s) as ir	5.2		1	
	Erika Sperbeck	Chief	f Deputy Director		
	Print Name		Title	(month, day, year)	
Comment:					
(Use this space or an attachment for a	ny additional information)			FPPC Form 801 (Jan/14)	

advice@fppc.ca.gov

Payment to Agency R	eport	A Public D	ocument		PAYMENT TO AGENCY REPORT	
1. Agency Name	2			Date Stamp	California Q 0 1	
Department of Health	Care Services	500	Form OUI			
Division, Department, or Reg	gion (if applicable)				For Official Use Only	
Administration Division	ո, Human Resoւ	ırces Branch			8	
Street Address					14 14 HCS	
P.O. Box 997411, MS						
Area Code/Phone Number	Email			Amendment (expl	ain in comment section)	
(916) 552-8270		rest@dhcs.ca	.gov	Date of Original Filin	n:	
Agency Contact (name and title Conflict of Interest Filin				(month, day, year)		
2. Donor Name and Addre	ess			CA School Nurses	Association	
☐ Individual	First	Name	Other		Name	
3511 Del Paso Road, Ste.		Sacramento		CA	95835	
Address	5	City		State	Zip Code	
The mission of CSNO is to	ensure that school	nurses optimize	student hea	lth and enhance lea	rning through a network.	
If "Other" is marked, describe the entity	's business activity (if busin	ess) or its nature and int	terests.			
If applicable,	identify the name of e	each source and the	e amount(s) re	eceived by the donor f	or this payment:	
2	,		. ,		*	
Name	\$	Amount		Name	\$	
3. Payment Information (C	Complete Section	ns 3.1 (a or b),	3.2, 3.3)			
3.1 (a) Travel Payment	Albuquerque,			Octo	ber 1-4, 2019	
•	- 1	Location of Travel		-	Dates (month, day, year)	
South West Airlines		☑ Air ☐ Bu	us 🗌 Auto	o ☐ Other	Andaluz	
Transportation Provider		Check Applicable Bo	oxes		Name of Lodging Facility	
\$\frac{695.28}{\text{Lodging Expenses}}	211.00	\$298.00		130.89	\$	
	Meal Expenses	Transportation Ex	penses	Other Expenses	Total Expenses	
3.1 (b) Payment(s) not re	lated to travel:		Dates (month, o	\$	Total Expenses	
3.2 Payment Description	Provide a specif	fia description o		12	10000000000000000000000000000000000000	
3.2. Payment Description						
To attend the 2019 Na	tional Alliance to	or Medicaid in	Education	(NAME) from O	ctober 1-4, 2019.	
3.3. Identify the officials v		ment in Section				
Mills	Jacob			ices Mgr II	DHCS/LGFD	
Last Name	First Nam	ne	Posi	ition/Title	Department/Division	
Last Name	First Nam	ne	Pos	ition/Title	Department/Division	
4. Verification		20		2		
Managed Annie (Managed Control of	he reported na	vment(s) as in co	mpliance wi	th FPPC regulations	3	
	Erika Sperb	•		Deputy Director	01/28/20	
	- Enka oper	Print Name		Title	(month, day, year)	
Α 1/2				MANON.	(monal, day, year)	
Comment:						
(Use this space or an attachment	ror any additional inform	iation)			FPPC Form 801 (Jan/14)	

advice@fppc.ca.gov