Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Department of Health Care Services

Division, Department, or Region (if applicable)

Administration Division, Human Resources Branch

Street Address

P.O. Box 997411, MS 1300

Area Code/Phone Number: (916) 552-8270

Email: ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Association of Medicaid Directors (Name)

444 North Capitol St., NW, Suite 267 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent and support the Medicaid Director's in 50 states, territories & the District of Columbia

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Washington, DC (Location of Travel) 11/10/19-11/13/19 (Dates (month, day, year))

United (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$893.16 Lodging Expenses | $141.00 Meal Expenses | $606.61 Transportation Expenses | $160.41 Other Expenses | $1,801.18 Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

To attend the NAMD conference in Washington DC.

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

Last Name	First Name	Position/Title	Department/Division
Cantwell	Mari	Chief Deputy Director	Director's Office

4. Verification

[redacted] reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 11.22.19 (month, day, year)

Comment:

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

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☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Association of Medicaid Directors (Name)

444 North Capitol St., NW Suite 267 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent and support the Medicaid Directors in 50 states, territories, & Disctrict of Columbia.

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_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Washington, DC (Location of Travel) 11/10/19 - 11/13/19 (Dates (month, day, year))

United (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$893.16	$128.00	$725.74	$31.99	$1,778.89
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

Payment was for attendance of the NAMD Fall 2019 conference in Washington, DC.

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

Last Name	First Name	Position/Title	Department/Division
Brooks	Sarah	Deputy Director	Health Care Delivery Systems

4. Verification

[redacted] reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 11.25.19 (month, day, year)

Comment:

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Agency Contact (name and title)

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☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Association of Medicaid Directors (Name)

444 North Capitol St., NW, Suite 267 (Address) Washington (City) DC (State) 20001 (Zip Code)

NAMD's sole function is to represent and support the Medicaid Director's in 50 states, territories & the District of Columbia

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Washington, DC (Location of Travel) 11/10/19-11/13/19 (Dates (month, day, year))

United; Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$893.16 (Lodging Expenses) $164.00 (Meal Expenses) $619.45 (Transportation Expenses) $20.00 (Other Expenses) $1,696.61 (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

To attend the NAMD conference in Washington DC.

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	Senior Advisor	Director's Office

4. Verification

[redacted] the reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 11.22.19 (month, day, year)

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Agency Contact (name and title)

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☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name) ☑ Other CA Advocates for Nursing Home Reform (CANHR) (Name)

650 Harrison Street (Address) San Francisco (City) CA (State) 94107 (Zip Code)

CANHR is dedicated to improve the choices, care and quality of life for CA's long-term care consumers.

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Monterey, CA (Location of Travel) 11/22-23/2019 (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☑ Auto ☐ Other (Check Applicable Boxes) Monterey Hotel & Spa (Name of Lodging Facility)

$225.55 (Lodging Expenses) $_____ (Meal Expenses) $211.70 (Transportation Expenses) $_____ (Other Expenses) $437.25 (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

To attend and participate at the Elder Law Attorney conference in an "Ask the Expert" session.

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

Last Name	First Name	Position/Title	Department/Division
Jones	Dennis	Attorney	Office of Legal Services

4. Verification

[redacted] reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.23.20 (month, day, year)

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Email: ConflictofInterest@dhcs.ca.gov

Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other National Association of Medicaid Directors (Name)

444 North Capitol St., NW, Suite 267 (Address) Washington (City) DC (State) 20001 (Zip Code)

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→ If applicable, identify the name of each source and the amount(s) received by the donor for this payment:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Washington, DC (Location of Travel) 11/10/19-11/13/19 (Dates (month, day, year))

United; Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Washington Hilton (Name of Lodging Facility)

$893.16 (Lodging Expenses) $164.00 (Meal Expenses) $618.05 (Transportation Expenses) $20.00 (Other Expenses) $1,695.21 (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

To attend the NAMD conference in Washington DC.

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	Senior Advisor	Director's Office

4. Verification

[redacted] the reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 1.23.20 (month, day, year)

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Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other California Primary Care Association (Name)

1380 Harbor Island Drive (Address) | San Diego (City) | CA (State) | 92101 (Zip Code)

CPCA leads in community clinics, health centers, and networks through advocacy.

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

San Diego, CA (Location of Travel) | 10/18/19-10/18/19 (Dates (month, day, year))

Southwest (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | N/A (Name of Lodging Facility)

$_____ (Lodging Expenses) $_____ (Meal Expenses) $_____ (Transportation Expenses) $_____ (Other Expenses) $_____ (Total Expenses)

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $ 150.00 (Total Expenses)

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

CPCA has agreed to reimburse the Department for travel costs up to $150. The work of the CPCA is to lead and position community clinics, health centers, and networks through advocacy, education and services. Dr. Mark attended the meeting to educate providers regarding statewide trauma screenings.

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

Last Name	First Name	Position/Title	Department/Division
Mark	Karen	Medical Director	Office of the Medical Directo

4. Verification

[redacted] the reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 1.28.20 (month, day, year)

Comment:

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Area Code/Phone Number: (916) 552-8270

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Agency Contact (name and title)

Conflict of Interest Filing Officer

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☑ Other CA School Nurses Association (Name)

3511 Del Paso Road, Ste. 160 (Address) | Sacramento (City) | CA (State) | 95835 (Zip Code)

The mission of CSNO is to ensure that school nurses optimize student health and enhance learning through a network.

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:

_____ (Name) $_____ (Amount) _____ (Name) $_____ (Amount)

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

3.1 (a) Travel Payment

Albuquerque, New Mexico (Location of Travel) | October 1-4, 2019 (Dates (month, day, year))

South West Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Andaluz (Name of Lodging Facility)

$695.28	$211.00	$298.00	$130.89	$1,335.17
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: _____ (Dates (month, day, year)) $_____ (Total Expenses)

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

To attend the 2019 National Alliance for Medicaid in Education (NAME) from October 1-4, 2019.

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

Last Name	First Name	Position/Title	Department/Division
Mills	Jacob	Staff Services Mgr II	DHCS/LGFD

4. Verification

([redacted]) he reported payment(s) as in compliance with FPPC regulations.

Print Name	Title	(month, day, year)
Erika Sperbeck	Chief Deputy Director	01/28/20

Comment:

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