Payment to Agency R	keport .	A Public Doc	ument			PAYMENT TO AGENCY REPORT
1. Agency Name	WHOLE SHALL BOWN BY SHALL APPRING			Date Sta	amp	California 201
Department of Health Care			Form OUI			
Division, Department, or Region (if applicable)						For Official Use Only
Administration Division, Hu						
Street Address		San of the				
P.O. Box 997411, MS 130	0					
Area Code/Phone Number	Email			7-1		******************************
(916) 552-8270	ConflictofInterest	@dhcs.ca.gov		Amendme	ent (explain	in comment section)
Agency Contact (name and title)				Date of Origin	al Filing:	
Conflict of Interest Filing O						(month, day, year)
2. Donor Name and Addre						
2. Donor Name and Addre	ess			Acadomy Ho	alth (Co	ntracted by CDC)
☐ Individual	Circle	Name [Other	Academy ne		Name
1666 K St NW #1100	First Name Washington DC			DC 20006		
Address		City			State	Zip Code
Academy Health is an orga	anization dedicated	to educating consum	ners and	nolicymakers	about th	e importance of health s
If "Other" is marked, describe the entity		270		policymanore	about tr	io importanto oi froditir c
	o baomeoc douvily (ii baom	oso, or no matero and micros				
If applicable,	identify the name of e	ach source and the am	ount(s) re	eceived by the	donor for	this payment:
	\$					\$
Name		Amount		Name		Amount
3. Payment Information (0	Complete Section	ns 3.1 (a or b), 3.2	, 3.3)			
3.1 (a) Travel Payment	Atlanta , Geor	gia			Januar	y 23-25, 2019
(-,		ocation of Travel		- 3	ī	Dates (month, day, year)
Delta Airlines	Rail	☑ Air ☐ Bus	☐ Auto	Other	Sherato	on Atlanta Hotel
Transportation Provider		Check Applicable Boxes	L Auto		<u>N</u>	Name of Lodging Facility
318.00	40.00	688.40	•	0.00		1,046.40
Lodging Expenses	Meal Expenses	Transportation Expense	. \$. es	Other Expenses	- 4	Total Expenses
3.1 (b) Payment(s) not re	lated to travel:	N/	Α	\$	0.00	
(),		Dat	es (month, d	ay, year)		Total Expenses
3.2. Payment Description	. Provide a specif	ic description of th	e pavme	ent and its ac	iency pu	irpose and use.
250	\tag{2}	1.5.1	2.50 (.50)	-	20 1753 1510	7
To speak at a CDC org						
HIV prevention and tre	eaument benefits	. Exchange of pro	gramm	iatic and po	nicy rea	ated information.
3.3. Identify the officials v	who used the payr	ment in Section 3.1	(See instru	ctions)		
Wofford	Michael	Chi	ef, Pharr	macy Policy	DH	CS/Pharmacy Benefits
Last Name	First Nam	e	Posi	tion/Title		Department/Division
T-2FN-						
Last Name	First Nam	e	Posi	tion/Title		Department/Division
4. Verification						
	e reported pay	ment(s) as in compl	iance wi	th FPPC reau	lations.	7020
	Trike St	and and	OLA	L Drail.		42210
Signature	Cripa J	Print Name	UNK	Title	Direct	(month day year)
o.g.mary.o		2 10141191119		1109		(sitat, day, real)
Comment:						

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

Payment to Agency Re	port A Publ	lic Document	t	PAYMENT TO	AGENCY REPOR
1. Agency Name		NH	Date Stam	Califor	
Department of Health C	are Services		Form	estimite altitude setting setting at	
Division, Department, or Regi	on (if applicable)		1	For Offi	icial Use Only
Administration Division, Street Address	Human Resources Bra	nch	-		
P.O. Box 997411, MS 1	1300				
Area Code/Phone Number	Email		☐ Amendmen	t (explain in comment sec	etion)
(916) 552-8270	ConflictofInterest@dho	Total No. 17 - 17 Constitution of the Constitu			
Agency Contact (name and title)	2000 HM42	Date of Original	Filing:(month, day	/, year)	
Conflict of Interest Filing					
2. Donor Name and Addres	S			4 40 WARRED 35 DODGETS	Market Market COM
☐ Individual	First Name	Ø Other	National Acad	emy for State Hea	Ith Policy
Last Name 1233 20th Street N.W., Suite		aton		Name 20036	
Address	City	gion		State Zip Code	
If "Other" is marked, describe the entity's	business activity (if business) or its natur	e and interests.			
If applicable, ide	entify the name of each source a	and the emount(s) r	accived by the de	upor for this payment	in.
ii applicable, luc	shirly the name of each source a	and the amount(s) i	eceived by the do	mor for this payment	
Name	\$Amount	-	Name	\$	Amount
3. Payment Information (Co	omplete Sections 3.1 (a.c.	or b) 3 2 3 3)	200,0000,0000		7.000004.9909000000
3.1 (a) Travel Payment	Phoenix, AZ	7, 57, 6.2, 6.67	N	March 13-14, 2019)
o. r (a) maver r ayment	Location of Trave	el	-	Dates (month, da	
American Airlines	Rail 🗸 Air	☐ Bus ☐ Aut	o	Hilton Garden Inn	
Transportation Provider	10000 - 100 Day	cable Boxes	о <u>Пошо</u> г _	Name of Lodging	Facility
\$	76.25 \$ 332.8 Transports	33 ation Expenses \$.	8.75 Other Expenses	\$ 613.70	
Lodging Expenses	Meal Expenses Transporta	ation Expenses	Other Expenses	Total Exp	enses
3.1 (b) Payment(s) not rela	ted to travel:	5	\$_		
A A Business and a Business and a state of the same	Montperson to the source improvement as the position to receive source and	Dates (month, o		Total Expen	
3.2. Payment Description.	Provide a specific descript	tion of the payme	ent and its age	ncy purpose and	use.
57 S S V					
3.3. Identify the officials wh	no used the payment in Sec	ction 3.1 (See instru	ections)		
Logan, Julia			Medical Director	DHCS / OMD	
Last Name	First Name	Pos	ition/Title	Department	/Division
Last Name	First Name	Pos	ition/Title	Departmen	t/Division
l. Verification		114-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1			
	ne reported payment(s) as	s in compliance wi	th FPPC regular	tions	
	Erika Sperbeck	N	Deputy Directo		47219
Signature	Print Name		Title		onth, day, year)
Comment: (Use this space or an attachment for	any additional information				
(Ose this space of an attachment for	arry additional information)			EDDO E	004 / 1 /4 4

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