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 Academy Health (Contracted by CDC) (Name)

1666 K St NW #1100 (Address) | Washington DC (City) | DC (State) | 20006 (Zip Code)

Academy Health is an organization dedicated to educating consumers and policymakers about the importance of health se

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

Atlanta , Georgia (Location of Travel)

January 23-25, 2019 (Dates (month, day, year))

Delta Airlines (Transportation Provider)

☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Sheraton Atlanta Hotel (Name of Lodging Facility)

$318.00	$40.00	$688.40	$0.00	$1,046.40
Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses

3.1 (b) Payment(s) not related to travel: N/A (Dates (month, day, year)) $ 0.00 (Total Expenses)

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

To speak at a CDC organized national gathering of state healthcare policy makers on the topic of HIV prevention and treatment benefits. Exchange of programmatic and policy related information.

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

Last Name	First Name	Position/Title	Department/Division
Wofford	Michael	Chief, Pharmacy Policy	DHCS/Pharmacy Benefits

4. Verification

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

[redacted] (Signature) | Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 4.23.19 (month, day, year)

Comment:

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

Clear Page

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 Academy for State Health Policy (Name)

1233 20th Street N.W., Suite 303 (Address) Washington (City) DC (State) 20036 (Zip Code)

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

Phoenix, AZ (Location of Travel) March 13-14, 2019 (Dates (month, day, year))

American Airlines (Transportation Provider) ☐ Rail ☑ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Hilton Garden Inn (Name of Lodging Facility)

$195.87	$76.25	$332.83	$8.75	$613.70
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.

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

Last Name	First Name	Position/Title	Department/Division
Logan, Julia		Associate Medical Director	DHCS / OMD

4. Verification

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

Signature | Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 4.23.19 (month, day, year)

Comment:

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

Clear Page