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 Capitol Impact (Name)

1107 9th St #500 (Address) Sacramento (City) CA (State) 95814 (Zip Code)

Capitol Impact is a Sacramento based consulting firm dedicated to improving policy and practice in California

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

Jacksonville, FL (Location of Travel)

August 14-16, 2018 (Dates (month, day, year))

Delta Airlines (Transportation Provider)

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

Hyatt Regency Riverfront (Name of Lodging Facility)

$385.76	$33.71	$409.60	$116.00	$945.07
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 speak at a national gathering of state healthcare policy makers on the topic of HIV prevention and treatment benefits provided through California Medicaid (Medi-Cal).

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

Original Signed By: e reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) Chief Deputy Director (Title) 10.3.18 (month, day, year)

Comment:

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

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