

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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	Email	<input type="checkbox"/> Amendment (explain in comment section)	
(916) 552-8270	ConflictofInterest@dhcs.ca.gov	Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title)			
Conflict of Interest Filing Officer			

2. Donor Name and Address

Individual \_\_\_\_\_  Other National Association of Medicaid Directors

Last Name First Name Name

444 Capitol Avenue, Suite 524 Washington DC 20001

Address City State Zip Code

NAMD's sole function is to represent & support the Medicaid Directors in 56 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 Madison, Wisconsin June 10-13, 2018

Location of Travel Dates (month, day, year)

United Airlines  Rail  Air  Bus  Auto  Other The Edgewater

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 585.60 \$ 64.00 \$ 1,318.57 \$ 15.00 \$ 1,397.57

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

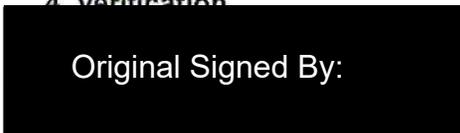
3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

To attend the National Association of Medicaid Director's (NAMD) Spring Conference from June 10-12, 2018 and NAMD's Scorecard Meeting on June 13, 2018

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

<u>Brooks</u>	<u>Sarah</u>	<u>Deputy Director</u>	<u>Health Care Delivery</u>
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division

4. Verification



Original Signed By:

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

Erika Sperbeck Chief Deputy Director 8.1.18

Print Name Title (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

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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	Email	<input type="checkbox"/> Amendment (explain in comment section)	
(916) 552-8270	ConflictofInterest@dhcs.ca.gov	Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Conflict of Interest Filing Officer			

**2. Donor Name and Address**

Individual \_\_\_\_\_  Other National Association of Medicaid Directors

\_\_\_\_\_ Last Name First Name Name

444 Capitol Avenue, Suite 524 Washington DC 20001

Address City State Zip Code

NAMD's sole function is to represent & support the Medicaid Directors in 56 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** Madison, Wisconsin June 10-12, 2018

Location of Travel Dates (month, day, year)

United Airlines  Rail  Air  Bus  Auto  Other The Edgewater

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 390.40 \$ 23.00 \$ 636.42 \$ 15.00 \$ 1,049.82

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 National Association of Medicaid Director's (NAMD) Spring Conference from June 10-12, 2018.

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

Harrington	Lindy	Deputy Director	Health Care Financing
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	L
Last Name	First Name	Position/Title	Department/Division

Original Signed By: [Redacted]

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

Erika Sperbeck Chief Deputy Director 8.1.18

Print Name Title (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

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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	Email	<input type="checkbox"/> Amendment (explain in comment section)	
(916) 552-8270	ConflictofInterest@dhcs.ca.gov	Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title)			
Conflict of Interest Filing Officer			

2. Donor Name and Address

Individual \_\_\_\_\_  Other National Quality Forum

Last Name First Name Name

1030 15th Street, NW Suite 800 Washington D.C. 20005

Address City State Zip Code

To improve health & performance of health system by supporting production & use of evidence to inform policy & practice.

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, D.C. 05/08/2018 - 05/10/2018

Location of Travel Dates (month, day, year)

United Airlines  Rail  Air  Bus  Auto  Other Hotel Rouge

Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 596.68 \$ 31.96 \$ 665.26 \$ \_\_\_\_\_ \$ 1,293.90

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 and participate at the National Quality Forum's Medicaid Adult In-person Meeting in Washington, D.C.

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

Logan	Julia	Public Health Medical Office	DHCS/OMD
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

Original Signed By:

Erika Sperbeck Chief Deputy Director 8.1.18

Print Name Title (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

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Agency Contact (name and title) Conflict of Interest Filing Officer			

2. Donor Name and Address

Individual \_\_\_\_\_  Other Academy Health

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 1666 K St. NW, Suite 1100 Washington DC 20006  
 Address City State Zip Code  
 AcademyHealth, is the professional home for health services researchers, policy analysts and practitioners.  
 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 May 2-4, 2018  
 Location of Travel Dates (month, day, year)

American Airlines  Rail  Air  Bus  Auto  Other The Darcy  
 Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ 647.21 \$ \_\_\_\_\_ \$ 570.10 \$ 70.76 \$ 1,288.07  
 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 attend the Medicaid Medical Directors Network AcademyHealth Spring Workshop in Washington, D.C.

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

Logan	Julia	Public Health Medical Office	DHCS/OMD
_____	_____	_____	_____
Last Name First Name	Position/Title	Department/Division	
_____	_____	_____	_____
Last Name First Name	Position/Title	Department/Division	

4. Verification

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

Original Signed By:

Erika Sperbeck

Chief Deputy Director

7.31.18

Print Name

Title

(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

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
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	Email	<input type="checkbox"/> Amendment (explain in comment section)	
(916) 552-8270	ConflictofInterest@dhcs.ca.gov	Date of Original Filing: 06/30/18	
Agency Contact (name and title)		(month, day, year)	
Conflict of Interest Filing Officer			

2. Donor Name and Address

Individual \_\_\_\_\_  Other NASADAD

\_\_\_\_\_ Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Name \_\_\_\_\_

1919 Pennsylvania Avenue NW, Suite M-250 Washington DC 20006

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

NASADAD supports the development of effective substance use disorder programs and policy.

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 D.C. May 21-24, 2018

Location of Travel \_\_\_\_\_ Dates (month, day, year) \_\_\_\_\_

American Airlines, \_\_\_\_\_  Rail  Air  Bus  Auto  Other Marriott Bethesda, MD

Transportation Provider \_\_\_\_\_ Check Applicable Boxes \_\_\_\_\_ Name of Lodging Facility \_\_\_\_\_

\$ 1,012.00 \$ 241.50 \$ 958.41 \$ \_\_\_\_\_ \$ 2,711.91

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.

Denise Galvez, as the National Prevention Network and Women's Services Network representative to California, attended the annual business meeting of the National Association of State Alcohol and Drug Abuse Directors. NASADAD provided travel stipends to meeting attendees.

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

<u>Galvez</u>	<u>Denise</u>	<u>Section Chief</u>	<u>DHCS, SUD-PPFD</u>
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

Original Signed By:

Erika Sperbeck

Chief Deputy Director

8.1.18

Print Name

Title

(month, day, year)

Comment:

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