

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address
Individual Other Academy Health (Contracted by CDC)
Last Name First Name Name
1666 K St NW #1100 Washington DC DC 20006
Address City State 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:

3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)
3.1 (a) Travel Payment
Atlanta, Georgia
January 23-25, 2019
Delta Airlines
Transportation Provider
Lodging Expenses \$318.00
Meal Expenses \$40.00
Transportation Expenses \$688.40
Other Expenses \$0.00
Total Expenses \$1,046.40
3.1 (b) Payment(s) not related to travel:
N/A
Total Expenses \$0.00

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

4. Verification
Signature: [Redacted]
Print Name: Erika Sperbeck
Title: Chief Deputy Director
Date: 4-23-19

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



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Agency Contact (name and title)			
Conflict of Interest Filing Officer			

2. Donor Name and Address

Individual \_\_\_\_\_  Other National Academy for State Health Policy

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

1233 20th Street N.W., Suite 303 Washington DC 20036

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ 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 March 13-14, 2019

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

American Airlines  Rail  Air  Bus  Auto  Other Hilton Garden Inn

\_\_\_\_\_ Transportation Provider \_\_\_\_\_ Check Applicable Boxes \_\_\_\_\_ 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)

Logan, Julia	Associate Medical Director	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.

Erika Sperbeck Chief Deputy Director 4.23.19

\_\_\_\_\_ Signature \_\_\_\_\_ Print Name \_\_\_\_\_ Title \_\_\_\_\_ (month, day, year)

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

