

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name Department of Health Care Services		Date Stamp	California Form 801 For Official Use Only
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 Capitol Impact

Last Name: _____ First Name: _____ Name: _____
 1107 9th St #500 Sacramento CA 95814
 Address City State 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 August 14-16, 2018

Location of Travel Dates (month, day, year)

Delta Airlines Rail Air Bus Auto Other Hyatt Regency Riverfront
 Transportation Provider Check Applicable Boxes 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)

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

4. Verification

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

Original Signed By: Erika Sperbeck Chief Deputy Director 10.3/19

Print Name Title (month, day, year)

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

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