# Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

**California Form 801**

For Official Use Only

Date Stamp

## 1. Agency Name

California Department of Health Care Services

Administration, Human Resources Division

PO Box 997411, MS 1300, Sacramento CA 95899-7411

| Area Code/Phone Number | Email |
|---|---|
| 916-552-8270 | ConflictOfInterestInquiry@dhcs.ca.gov |

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 California Assoc. of Public Hosp. & Hlth. Syst. (Name)

70 Washington Street, Suite 215 Oakland CA 94607

CAPH is a nonprofit 501(c)(6) organization that represents California's 21 public health care systems.

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**

Oakland, CA (Location of Travel) 10/03/2024 (Dates (month, day, year))

CharterUP (Transportation Provider) ☐ Rail ☐ Air ■ Bus ☐ Auto ☐ Other (Check Applicable Boxes) _____ (Name of Lodging Facility)

$_____ Lodging Expenses $_____ Meal Expenses $213.52 Transportation Expenses $_____ Other Expenses $213.52 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**

The Officials were invited to attend an educational site visit with the Department of Health Care Services' Department of Finance partners. Donor paid for transportation.

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

| Last Name | First Name | Position/Title | Department/Division |
|---|---|---|---|
| Harrington | Lindy | Asst. State Medicaid Dir. | Director's Office |
| Barrios | Brett | Staff Services Manager I | Financial Management Div. |

## 4. Verification

I authorized the acceptance of the reported payment(s) as in compliance with FPPC regulations.

| Signature | Print Name | Title | (month, day, year) |
|---|---|---|---|
| [redacted] | Erika Sperbeck | Chief Deputy Director | 01/22/25 |

Comment:

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



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