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, Human Resources Division

Street Address

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

Area Code/Phone Number	Email
916-552-8270	ConflictOfInterestInquiry@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 Association of Immunization Managers (Name)

Address	City	State	Zip Code
451 Hungerford Dr. Suite225	Rockville	MD	20850

Association of Immunization Managers is dedicated to establishing a nation free of vaccine-preventable disease.

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

Boise, Idaho (Location of Travel) 05/21/2024-05/23/2024 (Dates (month, day, year))

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

$ Lodging Expenses	$ Meal Expenses	$ Transportation Expenses	$ Other Expenses	$ Total Expenses
	115.00	332.95	58.46	506.41

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.

The official was invited to speak on behalf of DHCS to develop California-specific strategies to break down barriers to the successful vaccination of adults. Donor paid for meals, airfare, and registration fees.

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

Last Name	First Name	Position/Title	Department/Division
Mark	Karen	Medical Director for Pol/Ev	Quality & Pop. Hlth. Mgmt.

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	07/22/24

Comment:

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

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