

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, Human Resources Division Street Address P.O. Box 997411, MS 1300 Area Code/Phone Number (916) 552-8270 Email conflictofinterest@dhcs.ca.gov Agency Contact (name and title) Conflict of Interest Filing Officer		Date Stamp	California Form 801 For Official Use Only
		<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

☐ Individual _____ ☒ Other Santa Cruz County Dept. of Public Health
 Last Name First Name Name
 1080 Emeline Ave. Bldg. D 2nd Floor Santa Cruz CA 95060
 Address City State Zip Code
 Public Health Department oversees the Targeted Case Mgmt, County-Based Medical Admin. Activities Program
 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 Orange County, CA 05/02/2023-05/04/2023
 Location of Travel Dates (month, day, year)
 Southwest ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other Doubletree by Hilton
 Transportation Provider Check Applicable Boxes Name of Lodging Facility
 \$ 306.50 \$ 78.00 \$ 32.10 \$ 10.00 \$ 426.60
 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.

Official presented at the Local Governmental Agencies Conference in Orange County, CA.

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

Saleem	Anissa	Analyst	Local Govt. Financing Div.
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division

4. Verification

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

_____	Erika Sperbeck	Chief Deputy Director	07/14/23
Signature	Print Name	Title	(month, day, year)

Comment:

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