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

P.O. Box 997411, MS 1300, Sacramento, CA 95899-7411

Area Code/Phone Number

(916) 552-8270

Email

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 Keck School of Medicine of Univ. of So. Cal. (Name)

1540 Alcazar Street, CHP 223 (Address) | Los Angeles (City) | CA (State) | 90033 (Zip Code)

Organization that aims to drive innovation in health and medicine to serve communities.

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

Los Angeles, CA (Location of Travel) | 08/17/23 (Dates (mon h, day, year))

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

$_____ (Lodging Expenses) $_____ (Meal Expenses) $379.56 (Transporta ion Expenses) $_____ (Other Expenses) $379.56 (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 was invited by the agency for a speaker role for the 2023 5th Annual University of Southern California Street Medicine Conference.

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

Last Name	First Name	Position/Title	Department/Division
Cisneros	Bambi	Assistant Deputy Director	Health Care Delivery Syst.

4. Verification

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

[redacted] (Signature) | Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 10/20/23 (mon h, day, year)

Comment:

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

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