

# Payment to Agency Report

# A Public Document

PAYMENT TO AGENCY REPORT

|  |  |   |   |
|--|--|---|---|
| <b>1. Agency Name</b><br>Department of Health Care Services<br><b>Division, Department, or Region</b> (if applicable)<br>Administration, Human Resources Division<br><b>Street Address</b><br>P.O. Box 997411, MS 1300<br><b>Area Code/Phone Number</b><br>(916) 552-8270<br><b>Email</b><br>conflictofinterest@dhcs.ca.gov<br><b>Agency Contact</b> (name and title)<br>Conflict of Interest Filing Officer |  | Date Stamp  | <b>California Form 801</b><br>For Official Use Only |
|  |  | <input type="checkbox"/> <b>Amendment</b> (explain in comment section)<br><b>Date of Original Filing:</b> _____<br>(month, day, year) |   |

## 2. Donor Name and Address

☐ Individual \_\_\_\_\_ ☒ Other Kentucky Cabinet for Health & Family Svcs  
 Last Name First Name Name  
275 E. Main Street Frankfort KY 40621  
 Address City State Zip Code  
 State Government entity that administers programs to promote the mental and physical health of Kentuckians.  
 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** Louisville, Kentucky 5/30/23 - 6/1/23  
 Location of Travel Dates (month, day, year)  
United Airlines ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other Galt House Hotel  
 Transportation Provider Check Applicable Boxes Name of Lodging Facility  
 \$ 471.60 \$ \_\_\_\_\_ \$ 610.40 \$ 177.29 \$ 1,259.29  
 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

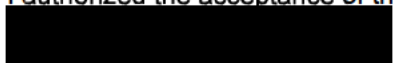
**3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.**  
 Requested CA State Medicaid Director to speak/present California's 1115 waiver.

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

|               |              |                                |                          |
|---------------|--------------|--------------------------------|--------------------------|
| <u>Cooper</u> | <u>Jacey</u> | <u>State Medicaid Director</u> | <u>Director's Office</u> |
| 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.

|  |                       |                              |                    |
|--|-----------------------|------------------------------|--------------------|
|  | <u>Erika Sperbeck</u> | <u>Chief Deputy Director</u> | <u>07/14/23</u>    |
| Signature  | Print Name            | Title                        | (month, day, year) |

Comment:

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