California 801 Cali	Payment to Agency R	eport	A Public [Document			PAYMENT TO AGENCY REPORT
Department of Health Care Services Division, Department, or Region (rappicate) Administration, Human Resources Division Street Address P.O. Box 997411, MS 1300 Area Code/Phone Number Email conflictofinterest@dhos.ca.gov Agency Contact (name and title) Conflict of Interest Filing Officer 2. Donor Name and Address Individual Last Name Frest Name Other Santa Cruz County Dept. of Public Health Name CA 95060 Public Health Department oversees the Targeted Case Mgmt, County-Based Medical Admin. Activities Program If applicable, identify the name of each source and the amount(s) received by the donor for this payment: If applicable, identify the name of each source and the amount(s) received by the donor for this payment: Name Annount Name Orange County, CA Double free ministry in the payment of the payment information (Complete Sections 3.1 (a or b), 3.2, 3.3) 3.1 (a) Travel Payment Orange County, CA Location of travel Southwest Framportation Provider 3.30.5.00 Southwest Rail Payment Agencies South Rail Payment and its agency purpose and use, Official attended the Local Governmental Agencies Conference in Orange County, CA to support his team's presentation at the conference. 3.1 (b) Payment(s) not related to travel: Dates (month, day, year) Double free minutions) Jones Matthew Manager I Local Govt. Financing Div. Last Name Frest Name Prosition/File Department/Division Last Name Frest Name Frest Name Prosition/File Department/Division Last Name Frest Name Frest Name Frest Name Title (month, day, year)	1. Agency Name	•			Date Sta	amp	
Administration, Human Resources Division Street Address P.O. Box 997411, MS 1300 Area Gode/Phone Number [Small conflictofinterest@dhcs.ca.gov Date of Original Filing: (Incette, day, year) Date of Original Fil							Form OU'I
Street Address P.O. Box 997411, MS 1300 Area Code/Phone Number (916) 552-8270 Conflict of Interest Filing Officer 2. Donor Name and Address Date of Original Filing:							For Official Use Only
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Area Code/Phone Number (916) 552-8270							
Amendment (explain in comment section) Date of Original Filling: Conflict of Interest Filing Officer	P.O. Box 997411, MS 1300)					
Online of Original Filing:	Area Code/Phone Number	Email			☐ Amendme	nt (ovolain	in comment section)
Conflict of Interest Filing Officer 2. Donor Name and Address Individual Last Name First Name Other Santa Cruz CA 95060	(916) 552-8270	conflictofinterest@dhcs.ca.gov		Amendment (explain in confinent section)			
Conflict of Interest Filing Officer 2. Donor Name and Address Individual Last Name First Name Santa Cruz CA 95060	Agency Contact (name and title)						
Individual Last Name First Name Other Santa Cruz Ca Solo	Conflict of Interest Filing Of	ficer					(month, day, year)
1080 Emeline Ave, Bidg D 2nd Floor	2. Donor Name and Addre	ss					
Total Expenses Signature First Name Santa Cruz CA 95060	□ Individual			■ Other	Santa Cruz (County [Dept. of Public Health
Address 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	Last Name	Last Name First Name			Name		
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3.1 (a) Travel Payment Orange County, CA	If applicable, i	dentify the name of e	ach source and the	he amount(s) re	eceived by the	donor for	this payment:
3.1 (a) Travel Payment Orange County, CA		\$					\$
Southwest	Name	Ψ	Amount		Name		Amount
Dates (month, day, year) Dates (month, day, year)	3. Payment Information (C	complete Section	ns 3.1 (a or b)	, 3.2, 3.3)			
Southwest	3.1 (a) Travel Payment	Orange Coun	ty, CA			05/02/2	2023-05/04/2023
Transportation Provider \$\frac{306.50}{\text{Lodging Expenses}} \frac{\$\frac{67.00}{\text{Meal Expenses}}}{\text{Meal Expenses}} \frac{\$\frac{87.11}{\text{Transportation Expenses}}}{\text{Dates (month, day, year)}} \frac{\$\frac{460.61}{\text{Total Expenses}}}{\text{Total Expenses}} \frac{3460.61}{\text{Total Expenses}} \frac{460.61}{\text{Total Expenses}} 3.1 (b) Payment(s) not related to travel: Dates (month, day, year)	, ,		ocation of Travel		-		Dates (month, day, year)
Sand Solution Provider Sand Solution Spenses Sand S	Southwest	□ Rail	■ Air □ E	Bus □ Auto	⊃ □ Other	Double	Tree Hilton
Total Expenses Meal Expenses Total Expenses Total Expenses Total Expenses	Transportation Provider			_			Name of Lodging Facility
3.1 (b) Payment(s) not related to travel: Dates (month, day, year) Total Expenses	S	67.00	_{\$} 87.11	\$			\$_460.61
3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use. Official attended the Local Governmental Agencies Conference in Orange County, CA to support his team's presentation at the conference. 3.3. Identify the officials who used the payment in Section 3.1 (See instructions) Jones Matthew Manager I Local Govt. Financing Div. Last Name First Name Position/Title Department/Division 4. Verification Last Name First Name Position/Title Department/Division 4. Verification Lathorized 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)	Lodging Expenses	Meal Expenses	Transportation E	xpenses	Other Expenses		Total Expenses
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		Erika Sperb	eck	Chief	Deputy Direc	tor	07/14/23
Comment:	Signature		Print Name		Title		(month, day, year)
	Comment:						

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