

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 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, KY 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
 \$ 484.02 \$ 54.00 \$ 792.18 \$ 0.00 \$ 1,330.20
 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.

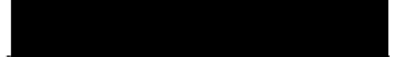
Travel to speak at the Kentucky Cabinet for Health and Family Services Mental Health Summit.

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

<u>Sadwith</u>	<u>Tyler</u>	<u>Deputy Director</u>	<u>Behavioral Health</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)