

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

1. Agency Name California Department of Health Care Services		Date Stamp	California Form 801 For Official Use Only
Administration, Human Resources Division			
PO Box 997411, MS 1300, Sacramento CA 95899-7411			
Area Code/Phone Number 916-552-8270	Email ConflictOfInterestInquiry@dhcs.ca.gov	<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	
Conflict of Interest Filing Officer			

2. Donor Name and Address

☐ Individual _____ ☒ Other California Assoc. of Public Hosp. & Hlth. Syst.
 Last Name First Name Name
 70 Washington Street, Suite 215 Oakland CA 94607

CAPH is a nonprofit 501(c)(6) organization that represents California's 21 public health care systems.

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
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3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

3.1 (a) Travel Payment Oakland, CA 10/03/2024
 Location of Travel Dates (month, day, year)

CharterUP ☐ Rail ☐ Air ☒ Bus ☐ Auto ☐ Other
 Transportation Provider Check Applicable Boxes Name of Lodging Facility

\$ _____	\$ _____	\$ 213.52	\$ _____	\$ 213.52
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

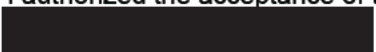
The Officials were invited to attend an educational site visit with the Department of Health Care Services' Department of Finance partners. Donor paid for transportation.

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

Harrington	Lindy	Asst. State Medicaid Dir.	Director's Office
Last Name	First Name	Position/Title	Department/Division
Barrios	Brett	Staff Services Manager I	Financial Management Div.
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	01/22/25
Signature	Print Name	Title	(month, day, year)

Comment:

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