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

PO 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 Integrated Healthcare Association (Name)

180 Grand Avenue, Suite 1365 (Address) Oakland (City) CA (State) 94612 (Zip Code)

501(c)(6) non-profit business league funded by the healthcare industry to solve industry-wide healthcare challenges.

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

Anaheim, CA (Location of Travel)

11/18/2025 -11/19/2025 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes)

Westin Anaheim Resort (Name of Lodging Facility)

$336.59	$0.00	$584.55	$100.73	$1,021.87
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.

The Official represented the Department of Health Care Services as its board member at the in-person Integrated Healthcare Association Board of Directors Meeting. Donor paid for transportation, lodging, and parking.

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

Last Name	First Name	Position/Title	Department/Division
Scott	Linette	Deputy Director & CDO	DHCS/EDIM

4. Verification

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

[redacted] Erika Sperbeck (Print Name) Chief Deputy Director (Title) 01/30/26 (month, day, year)

Comment:

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

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