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

P.O. 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 Center for Health Care Strategies (Name)

300 American Metro Blvd, Ste 125 (Address) Hamilton (City) NJ (State) 08619 (Zip Code)

CHCS is a policy design and implementation partner devoted to improving outcomes for people enrolled in Medicaid.

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

Detroit, MI (Location of Travel) 09/16/2024 - 09/18/2024 (Dates (month, day, year))

Southwest Airlines (Transportation Provider) ☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Detroit Foundation Hotel (Name of Lodging Facility)

$714.56 (Lodging Expenses) $_____ (Meal Expenses) $360.00 (Transportation Expenses) $_____ (Other Expenses) $1,074.56 (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.

Official was invited to discuss implementation of services to address Health Related Social Needs through Medi-Cal. Official was invited to discuss implementation of services to address Health Related Social Needs through Medi-Cal.

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

Last Name	First Name	Position/Title	Department/Division
Miller	Laura	Medical Consultant II	DHCS/QPHM/PHMD

4. Verification

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

[redacted] (Signature) Erika Sperbeck (Print Name) Chief Deputy Director (Title) 10/29/24 (month, day, year)

Comment:

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

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