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

Santa Monica, CA (Location of Travel) | 11/12/2024 - 11/13/2024 (Dates (month, day, year))

Private auto (Transportation Provider)

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

Hilton Santa Monica Hotel (Name of Lodging Facility)

$430.26 (Lodging Expenses) | $_____ (Meal Expenses) | $139.36 (Transportation Expenses) | $_____ (Other Expenses) | $569.62 (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 was invited to represent the Department of Health Care Services as its board member at the In-Person Board of Directors Meeting. Donor paid for transportation and lodging.

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	Enterprise Data & Info. Mgt.

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) | 01/22/25 (month, day, year)

Comment:

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

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