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

Area Code/Phone Number: (916) 552-8270

Email: ConflictofInterest@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: N/A — First Name:

■ Other — Name: Brd. of Trustees - Leland Stanford Jr Univ.

Address: 450 Jane Stanford Way — City: Stanford — State: CA — Zip Code: 94305

Stanford Brd. focused on leadership in pioneering research, creative teaching protocols, and effective clinical therapies.

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: N/A — $ Amount: — Name: — $ Amount:

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

3.1 (a) Travel Payment

Location of Travel: Arlington, VA

Dates (month, day, year): 5/4-5/5/2023

Transportation Provider: Southwest Airlines

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

Name of Lodging Facility: The Westin Crystal

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$273.06	$44.22	$734.57	$	$1,051.85

3.1 (b) Payment(s) not related to travel:

Dates (month, day, year): N/A

$ Total Expenses:

3.2. Payment Description. Provide a specific description of the payment and its agency purpose and use.

Mr. Freeman was invited to a brainstorming session regarding disincentives faced by children's medical device producers, particularly with regard to state Medicaid program reimbursement approvals. This is directly related to DHCS' functions and duties.

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

Last Name	First Name	Position/Title	Department/Division
Freeman	Michael	Asst. Dept. Dir, HCBE	Health Care Benefits & Elg.

4. Verification

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

Signature	Print Name	Title	(month, day, year)
[redacted]	Erika Sperbeck	Chief Deputy Director	07/14/23

Comment:

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

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