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
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 — Keck School of Medicine of USC (Name)

Address	City	State	Zip Code
540 Alcazar Street, CHP 223.	Los Angeles	CA	90033

Provision of formally accredited continuing Medical Education to physicians and other health care providers

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

Location of Travel: Los Angeles, CA
Dates (month, day, year): 08/12/2022

Transportation Provider: Keck Shcool of Medicine of USC

Check Applicable Boxes: ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other

Name of Lodging Facility: ____________

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$	$	$217.90	$	$217.90

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.

Requested CA State Medicaid Director to speak/participate in a panel regarding Street Medicine

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

Last Name	First Name	Position/Title	Department/Division
Cooper	Jacey	State Medicaid Director	Director's Office

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	

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