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) _____ (First Name)

■ Other CA. Assoc. of Health Plans (Name)

1415 L Street, Suite 850 (Address) | Sacramento (City) | CA (State) | 95814 (Zip Code)

The California Association of Health Plans (CAHP) is a statewide trade association representing health care plans.

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

San Diego, CA (Location of Travel) | 10/11/21 (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Manchester Grand Hyatt (Name of Lodging Facility)

$337.03 (Lodging Expenses) | $_____ (Meal Expenses) | $_____ (Transportation Expenses) | $_____ (Other Expenses) | $337.03 (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.

Jacey Cooper spoke at this CAHP annual conference, in her role as State Medicaid Director, on the issue of homelessness. The conference organizers covered one night of hotel stay.

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	Chief Deputy Director	Director's Office

4. Verification

[redacted] e reported payment(s) as in compliance with FPPC regulations.

Erika Sperbeck (Print Name) | Chief Deputy Director (Title) | 01/20/22 (month, day, year)

Comment:

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

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