

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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
Date Stamp
California Form 801
For Official Use Only
Amendment (explain in comment section)
Date of Original Filing: (month, day, year)

2. Donor Name and Address

Individual Other BRI Network
Last Name First Name Name
852 Franklin Avenue, Suite 205 Franklin Lakes NJ 07417
Address City State Zip Code

BRI Network creates conferences that improve organizational performance: bringing together industry leaders in health ca
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
Washington DC
Location of Travel
April 25-26, 2022
Dates (month, day, year)
Transportation Provider Rail Air Bus Auto Other
Check Applicable Boxes
Intercontinental Hotel
Name of Lodging Facility
\$ 343.70 \$ Meal Expenses \$ Transportation Expenses \$ Other Expenses \$ 343.70
Lodging Expenses 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.

Requested CA State Medicaid Director to speak at the Medicaid Managed Care Summit.

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

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

4. Verification

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

Signature Erika Sperbeck Chief Deputy Director 07/20/22
Print Name Title (month, day, year)

Comment:

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

