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

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

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 — Last Name _____ First Name _____

☒ Other — Substance Abuse and Mental Health Services (Name)

5600 Fishers Lane (Address) | Rockville (City) | MD (State) | 20857 (Zip Code)

SAMHSA leads public health efforts to advance the behavioral health of the nation.

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

Rockville, MD — Location of Travel

06/25/2024-06/27/2024 — Dates (month, day, year)

Southwest — Transportation Provider

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

Name of Lodging Facility: _____

$ _____ Lodging Expenses | $ _____ Meal Expenses | $ 822.96 Transportation Expenses | $ _____ Other Expenses | $ 822.96 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 speak as a representative of California as a part of the Housing and Services Partnership initiative. Donor paid for airfare.

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

Last Name	First Name	Position/Title	Department/Division
Tsang	Glenn	Policy Advisor	Health Care Delivery Systems

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) | 07/22/24 (month, day, year)

Comment:

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

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