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

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

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

☒ Other ACEs Resource Network (Name)

23091 Mill Creek Dr. (Address) | Laguna Hills (City) | CA (State) | 92653 (Zip Code)

Focus on Adverse Childhood Experiences, toxic stress and trauma-informed systems improvement

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

Los Angeles, CA (Location of Travel)

02/23/2026 - 02/25/2026 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

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

Kimpton Hotel Palomar LA (Name of Lodging Facility)

$994.00 Lodging Expenses | $276.00 Meal Expenses | $1,195.00 Transportation Expenses | $358.00 Other Expenses | $2,823.00 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 Officials were invited to participate in the development of a strategic framework for Medicaid's role in addressing toxic stress and ACEs, share implementation lessons, and support State action. Donor paid for lodging, transportation to/from convention, meals, and airfare.

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

Last Name	First Name	Position/Title	Department/Division
N/A	N/A	Assistant Division Chief	DHCS/QPHM
N/A	N/A	Supervisor I	DHCS/QPHM

4. Verification

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

[redacted] (Signature) | Lindy Harrington (Print Name) | Chief Deputy Director (Title) | 7/21/26 (month, day, year)

Comment:

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

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