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: Conflictinterestinquiry@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 NASADAD (Name)

1919 Pennsylvania Avenue NW, Suite M-250 (Address) Washington (City) D.C. (State) 20006-3456 (Zip Code)

NASADAD fosters and supports the development of alcohol and other drug use prevention and treatment programs .

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

Bethesda, MD (Location of Travel)

05/31/2026 - 06/03/2026 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

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

_____ (Name of Lodging Facility)

$ Lodging Expenses	$ 552.00 Meal Expenses	$ 1,881.70 Transportation Expenses	$ Other Expenses	$ 2,433.70 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 represent California as the Treatment Network Coordinator and Prevention Network Coordinator, as a requirement for federal grants received by SAMHSA. Donor paid for meals, transportation to/from convention, 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	Supervisor II	DHCS/CSD
N/A	N/A	Supervisor II	DHCS/CSD

4. Verification

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

[redacted] (Signature) _____ (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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