

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 _____ ☒ Other National Academy for State Health Policy
 Last Name First Name Name
 1233 20th St., N.W., Suite 303 Washington D.C. 20036
 Address City State Zip Code
 Nonpartisan organization committed to developing and advancing state health policy innovations and solutions.
 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 Alexandria, VA 06/13/2026 - 06/17/2026
 Location of Travel Dates (month, day, year)
 American Airlines ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other Hilton Alexandria Old Town
 Transportation Provider Check Applicable Boxes Name of Lodging Facility
 \$538.00 \$181.00 \$1,221.00 \$ _____ \$1,940.00
 Lodging Expenses Meal Expenses Transportation Expenses Other 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.

The Official was invited to present on the Transforming Maternal Health Model at the National Academy for State Health Policy, Maternity Care Deserts Policy Academy Conference. Donor paid for transportation, meals, and lodging.

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

Goh	Ying	Public Health Med. Officer	DHCS/QPHM
_____	_____	_____	_____
Last Name	First Name	Position/Title	Department/Division
_____	_____	_____	_____
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.

_____	Lindy Harrington	Chief Deputy Director	7/21/26
Signature	Print Name	Title	(month, day, year)

Comment:

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