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

P.O. 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 The California State Protocol Foundation (Name)

1700 Tribute Rd Ste 201 (Address) | Sacramento (City) | CA (State) | 95815 (Zip Code)

501(c)(3),The Mission Of The California State Protocol Foundation Is To Lessen The Burden On California Taxpayers.

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

Cambria, CA (Location of Travel) | 07/24/2024 - 07/26/2024 (Dates (month, day, year))

_____ (Transportation Provider)

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

Pelican Inn & Suites (Name of Lodging Facility)

$314.00	$	$	$	$314.00
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.

Official was invited to collaborate with other state officials to plan and strategize on departmental goals. Donor reimbursed the difference between the state rate and actual cost of room per night.

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

Last Name	First Name	Position/Title	Department/Division
Baass	Michelle	Director	DHCS/Director's Office

4. Verification

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

[redacted]	Erika Sperbeck	Chief Deputy Director	10/28/24
Signature	Print Name	Title	(month, day, year)

Comment:

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

Clear Page | Print Form