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 MLTSS Association (Name)

601 Massachusetts Ave., NW, Suite 520W (Address) Washington (City) DC (State) 20001 (Zip Code)

National organization focused on Managed Long Term Services and Supports.

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

Washington, D.C (Location of Travel)

09/24/2024 - 09/26/2024 (Dates (month, day, year))

Southwest Airlines (Transportation Provider)

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

Holiday Inn (Name of Lodging Facility)

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$605.26	$	$1,045.17	$900.00	$2,550.43

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.

Donor paid for air fare, event admission, lodging, and meals. Official was invited to be part of the panel and spoke about the Department of Health Care Services and Dual Eligible Special Needs Plans (D-SNPs).

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

Last Name	First Name	Position/Title	Department/Division
Dodson	Anastasia	Deputy Director	DHCS/OMII

4. Verification

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

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

Comment:

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

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