Payment to Agency Report — A Public Document

PAYMENT TO AGENCY REPORT

California Form 801

For Official Use Only

Date Stamp

1. Agency Name

Deparment 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	**Email**
(916) 552-8270	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 National Academy for State Health Policy (Name)

1233 20th St., N.W., Suite 303	Washington	DC	20036
Address	City	State	Zip Code

An organization that facilitates learning and interaction between policymakers and state officials on health policy issues.

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

Boston, MA (Location of Travel) — 08/13/23 - 08/16/23 (Dates (mon h, day, year))

Southwest Airlines (Transportation Provider) ☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) — Boston Marriott Copley Place (Name of Lodging Facility)

$862.00	$_____	$654.24	$_____	$1,516.24
Lodging Expenses	Meal Expenses	Transporta ion 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.

Donor covered airfare and lodging. Official represented the State as the Policy Advisor for Homelessness and Housing in the Health Related Social Needs Network meeting with other member states at NASHP's 36th Annual State Health Policy Conference.

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

Tsang	Glenn	Policy Advisor	Health Care Delivery Systm.
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.

[redacted] (Signature) — Erika Sperbeck (Print Name) — Chief Deputy Director (Title) — 10/20/23 (mon h, day, year)

Comment:

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

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