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 Brandeis University (Name)

415 South Street (Address) | Waltham (City) | MA (State) | 02453 (Zip Code)

Council on Health Care Economics & Policy at The Heller School for Social Policy & Management

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)

10/03/23 - 10/04/23 (Dates (month, day, year))

American Airlines (Transportation Provider)

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

Babson Exec. Conf. Center (Name of Lodging Facility)

$304.00	$92.00	$114.00	$122.00	$632.00
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.

Donor paid for air fare, event admission, lodging and meals. Official was part of the panel and spoke about Department of Health Care Services and Quality and Populations Health Management's population health efforts and California Advancing and Innovating Medi-Cal.

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

Last Name	First Name	Position/Title	Department/Division
Babaria	Palav	Deputy Director	Quality & Pop. Hlth. Mgmt.

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) | 01/16/24 (month, day, year)

Comment:

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

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