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

Area Code/Phone Number

(916) 552-8270

Email

conflictofinterest@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 Nat'l Assoc. State Alcohol & Drug Abuse Dir. (Name)

1919 Pennsylvania Ave, NW, Ste M-250 (Address) Washington DC (City) 20006 (State / Zip Code)

Fosters and supports the development of effective alcohol and other drug use prevention and treatment in every state.

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

Rockville, Maryland (Location of Travel)

6/25/23-6/28/23 (Dates (month, day, year))

United Airlines (Transportation Provider)

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

North Marriott Hotel (Name of Lodging Facility)

$947.61	$184.00	$1,356.32	$723.57	$3,211.50
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 one of the required attendees to represent the State at the National Association of State Alcohol & Drug Abuse Directors.

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

Last Name	First Name	Position/Title	Department/Division
Sabah	Waheeda	Manager I	Comm. Services 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) 07/14/23 (month, day, year)

Comment:

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

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