

Payment to Agency Report

A Public Document

PAYMENT TO AGENCY REPORT

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		Date Stamp	California Form 801 For Official Use Only
		<input type="checkbox"/> Amendment (explain in comment section) Date of Original Filing: _____ (month, day, year)	

2. Donor Name and Address

☐ Individual _____ ☒ Other Vanderbilt University
 Last Name First Name Name
230 Appleton Place Nashville TN 37203
 Address City State Zip Code
 Vanderbilt University works directly with state leaders to achieve their goals for child and parent wellbeing.
 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 Nashville, TN 07/09/2024 - 07/12/2024
 Location of Travel Dates (month, day, year)
Southwest Airlines ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other Nashville Marriott
 Transportation Provider Check Applicable Boxes Name of Lodging Facility
 \$ 717.00 \$ 66.98 \$ 763.02 \$ _____ \$ 1,547.00
 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 presented at a learning symposium. Donor paid for meals, airfare, and lodging.

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

<u>Mollow</u>	<u>Rene</u>	<u>Deputy Director, HCBE</u>	<u>DHCS/HCBE</u>
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.

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

Comment:

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