

# Payment to Agency Report

# A Public Document

PAYMENT TO AGENCY REPORT

<b>1. Agency Name</b>		Date Stamp	<b>California Form 801</b> For Official Use Only
Department of Health Care Services			
<b>Division, Department, or Region</b> (if applicable) Administration, Human Resources Division			
<b>Street Address</b> PO Box 997411, MS 1300, Sacramento CA 95899-7411			
<b>Area Code/Phone Number</b> 916 552-8270	<b>Email</b> ConflictOfInterestInquiry@dhcs.ca.gov	<input type="checkbox"/> <b>Amendment</b> (explain in comment section)  <b>Date of Original Filing:</b> _____ (month, day, year)	
<b>Agency Contact</b> (name and title) Conflict of Interest Filing Officer			

## 2. Donor Name and Address

☐ **Individual** \_\_\_\_\_ ☐ **Other** NASADAD

_____	_____	_____	_____
Last Name	First Name	Name	
1919 Pennsylvania Avenue, NW, Suite 250	Washington	DC	20006
Address	City	State	Zip Code

NASADAD is a national association of alcohol and drug abuse directors.

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:

SAMHSA (for provided meals)	\$ 237.00	NASADAD (for hotel, air, lyft)	\$ 1,810.00
Name	Amount	Name	Amount

## 3. Payment Information (Complete Sections 3.1 (a or b), 3.2, 3.3)

**3.1 (a) Travel Payment**

Bethesda, MD	06/01/2024-06/05/2024
Location of Travel	Dates (month, day, year)

United Airlines ☐ Rail ☒ Air ☐ Bus ☐ Auto ☐ Other

Check Applicable Boxes

Hyatt Regency
Name of Lodging Facility

\$ 880.00	\$ 237.00	\$ 814.77	\$ 115.00	\$ 2,046.77
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.

The official was invited to represent California as the National Prevention Network Prevention Coordinator. Donor paid for hotel, meals, transportation to and from the convention, and airfare.

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

Galvez	Denise	Manager III	Comm. Services Division
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.

_____	Erika Sperbeck	Chief Deputy Director	07/22/24
Signature	Print Name	Title	(month, day, year)

Comment:

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