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
PO 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 National Committee for Quality Assurance (Name)

Address	City	State	Zip Code
1100 13th Street, NW, Third Floor	Washington	DC	20005

NCQA seeks to improve health care through proven quality measures.

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

Location of Travel: Washington, D.C.

Dates (month, day, year): 05/08/2024-05/10/2024

Transportation Provider: United Airlines

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

Name of Lodging Facility: The Madison Hotel

Lodging Expenses	Meal Expenses	Transportation Expenses	Other Expenses	Total Expenses
$ 299.00	$ 158.00	$ 828.30	$ 212.61	$ 1,497.91

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 participate on a voting board that meets once a year in person. Donor paid for airfare, hotel, meals, and ground transportation.

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.

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

Comment:

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

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