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 Princeton University (Name)

20 Washington Road Princeton (Address) | Princeton (City) | NJ (State) | 08544 (Zip Code)

Program focuses on assisting states w/ transforming their health care systems to be affordable, equitable, and innovative.

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

Denver, Colorado (Location of Travel)

06/26/2024-06/28/2024 (Dates (month, day, year))

United Airlines (Transportation Provider)

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

Magnolia Hotel Denver (Name of Lodging Facility)

$460.68	$82.61	$496.34	$	$1,039.63
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 asked to speak on a panel at the Princeton University, State Health and Value Strategies' Non-Citizen Coverage Convening. Donor paid for airfare, hotel, and meals.

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

Last Name	First Name	Position/Title	Department/Division
Mollow	Rene	Deputy Director, HCBE	Health Care Benefits & Elig.

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) | 07/22/24 (month, day, year)

Comment:

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

Clear Page | Print Form