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	Email
916-552-8270	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 Medicaid State Dental Association (Name)

4411 Connecticut Ave, N.W. #401 (Address) Washington (City) DC (State) 20008 (Zip Code)

MSDA's mission is to improve Medicaid, Medicare, and CHIP oral health programs by collaborating with key stakeholders.

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

Alexandria, VA (Location of Travel) 05/04/2024-05/07/2024 (Dates (month, day, year))

United Airlines (Transportation Provider) ☐ Rail ■ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) Alexandrian Autograph Coll. (Name of Lodging Facility)

$ 648.48	$	$ 607.50	$ 665.00	$ 1,920.98
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 presented session on "Care Coordination and Case Management" at the conference. Donor paid for hotel, airfare, and part of registration fee.

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

Last Name	First Name	Position/Title	Department/Division
Alcara-Beshara	Adrianna	Division Chief	Medi-Cal Dental Services

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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