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

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

☐ **Amendment** (explain in comment section)

Date of Original Filing: _____ (month, day, year)

2. Donor Name and Address

☐ Individual _____ (Last Name) _____ (First Name)

■ Other CA Advocates for Nursing Home Reform (Name)

1803 6th Street (Address) | Berkeley (City) | CA (State) | 94710 (Zip Code)

Non-profit organization dedicated to improving choices, care, and quality of life for California's long term care consumers.

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

Monterey, CA (Location of Travel) | 11/17/23 - 11/18/23 (Dates (month, day, year))

_____ (Transportation Provider)

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

Monterey Plaza Hotel (Name of Lodging Facility)

$310.60	$_____	$_____	$44.30	$354.90
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.

Donor paid for lodging and parking. Official participated on the panel at the California Advocates for Nursing Home Reform Elder Law Conference as a subject matter expert.

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

Last Name	First Name	Position/Title	Department/Division
Hoffeditz	Margaret	Assistant Deputy Director	Program Operations

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)	01/16/24 (month, day, year)

Comment:

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

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