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: 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) | 11/21/2025 - 11/22/2025 (Dates (month, day, year))

_____ (Transportation Provider) ☐ Rail ☐ Air ☐ Bus ☐ Auto ☐ Other (Check Applicable Boxes) | Monterey Plaza Hotel and Spa (Name of Lodging Facility)

$388.50 (Lodging Expenses) | $_____ (Meal Expenses) | $_____ (Transportation Expenses) | $_____ (Other Expenses) | $777.00 (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 officials were invited to speak and participate on the panel as Subject Matter Experts at the 2025 CA Advocates for Nursing Home Reform Elder Law Conference. Donor paid for lodging.

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

Last Name	First Name	Position/Title	Department/Division
Hill	Oksana	CEA/Division Chief	DHCS/TPLRD
n/a	n/a	SSM III/Branch Chief	DHCS/TPLRD

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) | 01/30/26 (month, day, year)

Comment:

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

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