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 Filling 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 Pace Association (Name)

675 N Washington St, Suite 300 (Address) Alexandria (City) VA (State) 22314 (Zip Code)

NPA is a 501(c)(3) organization that supports PACE to help frail seniors live independently via community-based care.

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, Virginia (Location of Travel) 10/15/2025 - 10/17/2025 (Dates (month, day, year))

Delta Air Lines and Uber (Transportation Provider)

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

Sheraton Suites (Name of Lodging Facility)

$637.76 (Lodging Expenses) $_____ (Meal Expenses) $1,048.43 (Transportation Expenses) $_____ (Other Expenses) $1,686.19 (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 invited to collaborate with other state officials to assess the current evidence and opportunities for scaling the PACE model. Donor paid for lodging and transportation.

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

Last Name	First Name	Position/Title	Department/Division
Solis	Lauren	Chief	DHCS/OMII

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)

Clear Page Print Form