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 Benefits Trust Data (Name)

Centre Square, West 1500 Market St #2800 (Address) Philadelphia (City) PA (State) 19102 (Zip Code)

Benefits Trust Data partners with government agencies to provide technical assistance and adopt policy solutions.

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

Philadelphia, PA (Location of Travel)

11/06/2023 - 11/09/2023 (Dates (month, day, year))

Delta/American Airlines (Transportation Provider)

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

Element Philadelphia Dwntwn (Name of Lodging Facility)

$700.59	$100.00	$575.40	$	$1,375.99
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 airfare, lodging, ground transportation and meals. Official presented implementation of the Continuous Coverage Unwinding policies and operational strategies, and identified additional opportunities/best practices to reduce discontinuance of Medi-Cal members.

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

Last Name	First Name	Position/Title	Department/Division
Huang	Yingjia	Asst. Dept. Dir, HCBE	Health Care Benefits & Elg.

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)	01/19/24 (month, day, year)

Comment:

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

Clear Page